Psychological symptoms in migrant women and women born in the UK

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Abstract:

Purpose:

This mixed-methods study aimed to investigate the relationship between migration and psychological symptoms for women living in London.

Methods:

Data from a cross-sectional survey (the South East London Community Health Study) were analysed to investigate whether first generation migrant women were significantly more likely to experience high levels of psychological symptoms (for common mental disorders (CIS-R) or Post Traumatic Stress Disorder (4 item PTSD screen)) than women born in the UK. Exploratory analyses investigated what migration specific variables may increase the risk of experiencing high levels of psychological symptoms.

Qualitative in-depth interviews with a purposive sample of migrant women and women born in the UK investigated what experiences women perceive impacted on their mental health and well-being, how they have been affected, and how this differs for migrant women and women born in the UK. A thematic analysis was carried out.

Results:

391 migrant women and 553 women born in the UK were included in the survey. There was no significant difference in the odds of experiencing high levels of psychological symptoms for migrant women compared with women born in the UK (AOR: 1.0 [95% CI 0.7-1.6]). Stressful life events and long standing physical conditions were associated with an increased risk of experiencing psychological symptoms, and were highly prevalent among migrant women and women born in the UK.

Twenty migrant women and ten women born in the UK participated in the qualitative interviews. Processes of marginalisation, disempowerment, and isolation contributed to women's exposure to stressful life events, and changes in their mental health and well-being. Coping processes were also identified.

Conclusions:

Services must consider exposure to stressful events, comorbidities, and underlying processes when addressing the mental health needs of women.

Acknowledgments:

First, I would like to thank the women who participated in this research, who bravely shared their own experiences in order to benefit the wider community of women. I would also like to thank the gatekeepers, translators, researchers, transcribers, and other professionals who contributed to this research.

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Glossary of terms

Migrant: An individual who has emigrated from their country of birth and is residing in a country in which they were not born.

Second generation migrant: An individual who was born in the country in which they are residing, but whose parent(s) immigrated to that country.

Ethnicity: This term refers to a group, community, or characteristic with which an individual identifies defined by cultural, social, religious, historical, geographical, linguistic, ancestral, national, or political experience or background.

Forced migrants: Individuals who have been forced to migrate away from their homes due to an element of coercion, which can relate to threats to life or livelihood (natural disaster, famine, conflict, persecution), or forced movement by others (e.g. trafficking). Forced migrants may include refugees, asylum seekers, and trafficked people.

Asylum: Protection granted by the government to an individual seeking refugee status for whom there is a high risk that they will experience persecution, torture, inhuman or degrading treatment or punishment, or threat to their life if they return to their country of origin.

Asylum seeker: An individual who is currently seeking refuge or asylum in the country to which they have immigrated.

Refugee: An individual who has been granted asylum or refuge in the country to which they have immigrated and in which they sought asylum.

Trafficked person: This thesis uses the definition of human trafficking as stated in the United Nations' Protocol to Prevent, Suppress and Punish Trafficking in Persons**,** which defines trafficking in persons as: "the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs."

Acculturation: The processes of assimilation, integration, and marginalisation, and the cultural and psychological changes that accompany this, during the period of settlement following migration.

Stress: The tension, worry, anxiety, strain, wear or other emotional responses to situations which are felt to be challenging or demanding.

Trauma: An adverse experience or event which is perceived to cause severe distress, disruption, pain, injury, or damage to an individual, either physically or emotionally. In relation to the stressful events examined in chapters 3 and 4, potentially traumatic stressful life events were those events included in the South East London Community Health Study which presented a threat to one's physical integrity or life.

Chapter 1: Introduction: The relationship between migration and psychological symptoms

1.1 Introduction

There is considerable evidence that women are more likely to experience symptoms of common mental disorders (including depression and anxiety) and Post Traumatic Stress Disorder (PTSD) (the symptoms focused on in this PhD) compared to men in low, medium, and high income settings [1-8] (though the reverse has been found for some psychotic disorders (e.g. schizophrenia) [9]). There are several possible explanations for these gender differences in the prevalence of symptoms of common mental disorders and PTSD including differences in exposure to stressful life events. This postulated explanation is supported by research that has shown that women experience an increased risk of exposure to interpersonal and sexual violence compared to men [10-12], and exposure to these events has been shown to be associated with an increased risk of psychological symptoms [13-18].

Migrant women may be at particularly increased risk of experiencing psychological symptoms both due to the stressors associated with migration [13-23], and because female migrants are at increased risk of experiencing psychological symptoms compared to male migrants (consistent with other populations) [15, 18, 24-29]. However, there is inconsistent evidence in the literature regarding whether migrants are at increased risk of experiencing high levels of psychological symptoms compared to native populations [19] (though migrants have been shown to be at increased risk of psychotic disorders [9, 19, 30]). This may be due to the heterogeneity of the populations studied (e.g. in terms of country of origin, trajectory of migration, or exposure to stressful life events), study methods, or psychiatric measures [30, 31]. Furthermore, studies often fail to examine gender differences in migrants' risk of psychological symptoms, or differences in rates of psychological symptoms between migrant and non-migrant women specifically. This may contribute to the discrepancies in findings across studies, and has resulted in a gap in knowledge of migrant women's mental health needs. I have therefore explored the mental health of migrant women in this mixed-methods doctoral research project which specifically investigates the impact of migration and stressful life events on the mental health and well-being of women in the UK.

In this chapter, I summarise existing research on the relationship between migration and the risk of experiencing high levels of psychological symptoms (including common mental disorders and PTSD). I then present a focused review of the research literature on psychological symptoms in migrant communities in the UK to provide more insight into the populations studied in this thesis.

1.2 Summary of research on migration and mental health

There are inconsistent findings in the literature regarding whether migrants are at increased risk of experiencing psychological symptoms compared with native populations (in their country of origin or destination country) [19, 32]. There is some evidence that migrants experience lower rates of psychological symptoms compared to native populations. The 'healthy migrant hypothesis' suggests that this may be because individuals with a lower risk of experiencing high levels of psychological symptoms are more likely to migrate (or to successfully migrate) or because migrants experience improved mental health due to improved conditions in destination countries [17, 32-39]. However, other research has found that migrants are at increased risk of experiencing high levels of psychological symptoms compared to native populations. The 'migration morbidity hypothesis' suggests that this may be because individuals who migrate experience increased risk either due to exposure to stressors during the migration process, or because poor mental health predicts migration [14-18, 26, 27, 32-38].

There are several factors that may contribute to such discrepancies in findings, including the heterogeneity of migrant populations and variation across studies in the populations investigated, definitions of migration used, study methods, or outcomes examined [30, 31], which I discuss further below. It is difficult to compare studies, as the type, onset, and severity of mental health outcomes are not consistently measured across migrant populations or between individuals. Furthermore, adverse health outcomes may develop over time, and positive health outcomes or a lack of symptoms may only be temporary [15, 17, 31, 32]. Conceptualisations of 'mental illness' also vary across populations. Some migrants may not utilise biomedical illness models or psychiatric terminology, and may present 'somatic' symptoms or cultural idioms of distress. Diverse illness models or representations of illness may present barriers to the use or validity of measures for common mental disorders or PTSD. Language barriers may present similar limitations, as well as resulting in selection bias. These factors make the

associations between migration and mental health difficult to isolate or measure [33]. However, variations in findings may also be affected by a failure in much of the research to examine gender differences in mental health outcomes or exposure to risk factors (e.g. disaggregating for men and women), as the prevalence of mental disorders or exposure to risk factors is likely to be different for male and female migrants.

I will first summarise research supporting the 'healthy migrant hypothesis'. Then, I will discuss the literature supporting the 'migration morbidity hypothesis', focusing on psychological symptoms, relevant risk factors, and, where evidence exists, gender differences in the risk of psychological symptoms and the associated risk factors.

1.2.1 Healthy migrant hypothesis

Studies on some migrant populations, particularly Latino migrants to the United States, have identified that migrants experience better mental health than native populations in their countries of origin or in host countries [34-40]. These findings have been suggested to be explained by improved conditions and quality of life, or increased access to 'buffering' resources for some migrant populations [17, 39]. Migrants may also be 'positively selected' for migration: migrating individuals may be more likely to be prime-aged, migrating because of pull factors like improved quality of life, have access to more resources (e.g. financial, or social), or have better mental health status, which facilitate successful migration. This is often referred to as the 'healthy migrant bias' [17, 41].

Some research has also shown that migrant populations may experience improved mental health outcomes following migration, even when exposed to migration related stressors, lower socio-economic status, and marginalisation [31, 36, 42]. This effect is often referred to as the healthy migrant 'paradox', and has primarily been described in relation to Latino migrant populations in the US [41]. This effect may exist because individuals who successfully migrate may be more likely to have good health, or because of improved conditions or a lack of exposure to acculturation stressors immediately following migration.

Evidence for the 'healthy migrant' hypothesis has been challenged, however. The research is limited in that: studies frequently only compare migrants to the native population in the receiving country (rather than the native populations in migrants'

countries of origin); often only include legal migrants and labour migrants and thus are not representative of other migrant populations (e.g. asylum seekers or trafficked populations who have been shown to be at increased risk of experiencing high levels of psychological symptoms [43]); are typically cross-sectional and thus provide no data on the mental health of migrants in the sample prior to their migration or changes in mental health over time following migration, as migrants' health may deteriorate (however, logistically longitudinal research with migrant populations is challenging); or use the utilisation of mental health services as a measure for mental health need, though underutilisation in migrant communities has been documented, attributed to factors like cultural or linguistic barriers, legal status, limited knowledge of available services, stigma, or use of informal or traditional resources, rather than a lack of mental illness [41, 44].

Findings showing better mental health in migrant populations may also be attributed to the 'salmon bias'. Overall morbidity rates may appear to be lower in migrant populations compared to native populations in receiving countries because migrants may return to their countries of origin and communities when ill and consequently be underrepresented in research [17, 45].

Findings suggesting migrants experience lower morbidity than native populations conflict with research supporting the 'migration morbidity hypothesis'.

1.2.2 Migration morbidity hypothesis

There is a significant body of research, supporting the 'migration morbidity hypothesis', which has identified poorer mental health outcomes in migrant populations compared with native populations [14-18, 26, 27, 46-52].

There are several theories about this relationship presented in the literature. Some research suggests that poor mental health may predict migration (e.g. individuals with mental disorders may migrate because they are stigmatised or isolated in their countries of origin, or to gain improved access to healthcare) [33, 52]. This theory is supported by Breslau et al's study, in which the relationship between migration and anxiety and mood disorders was investigated, comparing data from the US National Comorbidity Survey Replication for a sample of Mexican migrants to the US, and data from the Mexican National Comorbidity Survey for a sample of Mexicans living in Mexico. Their

findings suggested that pre-existing anxiety disorders predicted migration [48]. Breslau et al also identified, however, that migration predicted the onset of anxiety and mood disorders, as well as the persistence of anxiety [48].

Much recent research has attributed the increased risk of psychological symptoms in migrant populations to exposure to stressors prior to, during, and following migration including conflict, violence, exploitation, separation from loved ones, detention, poor living conditions, and acculturation stressors (e.g. stressors relating to living in a new culture) [13-23]. Refugee, asylum seeking, trafficked, and undocumented migrant populations may be at particularly increased risk of exposure to stressors, and consequently of experiencing high levels of psychological symptoms [43]. Furthermore, migrant populations may be more likely to experience multiple stressful life events than non-migrant populations, and research has suggested that levels of psychological symptoms increase with cumulative exposure to stressors [53-58].

1.2.3 Migration specific risk factors

There are a range of stressors that occur during the period leading up to migration, in transition between leaving one's country of origin and arriving in the destination country, and during resettlement, that have been shown to be associated with psychological symptoms for migrant populations [19, 59].

1.2.3.1 Pre-migration

Conditions in country of origin

Conditions in migrants' countries of origin or events leading to (and often catalysing) their migration, including poor socio-economic conditions, persecution, political violence, exploitation, and conflict, have been shown to increase the risk of experiencing psychological symptoms [13, 60-62]. These factors are also often associated with other stressors, for example violence, separation from or the death of loved ones, starvation, homelessness, or poor physical health, which have also been shown to increase the risk of psychological symptoms [63-66]. In many cases, these factors mean little preparation or planning is feasible prior to migration, and a lack of preparation or control over the decision to migrate has been shown to be associated with an increased risk of psychological symptoms [60, 61]. Forced migrants (including refugees, asylum seekers, and trafficked migrants) are broadly defined as individuals who have been

forced to migrate away from their homes due to an element of coercion, which can relate to threats to life or livelihood (natural disaster, famine, conflict, persecution), or forced movement by others (e.g. trafficking) [67]. Forced migration has been shown to be associated with an increased risk of exposure to stressful life events (e.g. trauma) prior to migration, and with high levels of psychological symptoms [18, 24, 30, 68-71].

Age at migration

Research has suggested that an association may exist between age at migration (which is also discussed in the context of acculturation in some research) and psychological symptoms. However, there are inconsistent findings in the literature regarding the effect of age at migration on psychological symptoms. Several studies have shown that the risk of experiencing psychological symptoms increases as the age at migration increases. For example, in their cross-sectional survey of 200 migrants from India in England, Cochrane and Stopes-Roe identified that the older the age at migration for male or female migrants, the more likely they were to experience high levels of psychological symptoms [72]. Studies also have found that younger age at migration is associated with a decreased risk of psychological symptoms. Using data from a national survey, Alegría et al identified that Latino men who migrated up until the age of 34 were significantly less likely to have a psychiatric disorder than men born in the US, though men who migrated after this age were not found to have significantly different odds. Women who migrated between the ages of 18 and 34 were also found to be significantly less likely to have a psychiatric disorder compared to women born in the US [73].

However, there is also research that suggests that older age at migration is associated with a decreased risk of psychological symptoms. For example, using data from the National Epidemiological Survey of Alcohol and Related Conditions in the US, Breslau et al identified that migrants from Mexico, Eastern Europe, and Africa and the Caribbean who migrated after the age of 13 were at decreased risk of mood and anxiety disorders compared to individuals born in the US. However, this was not true for migrants from these countries who migrated to the US before the age of 13 [34]. Research has also identified differences in the relationship between age and psychological symptoms between men and women. Using data from a national household survey, Williams et al identified that Black Caribbean men who migrated between the ages of

13-17 were significantly less likely to have a mood disorder than African American men born in the US. Women who migrated in this age range were not found to differ from women born in the US in their risk of having a mood disorder, however women who migrated to the US before the age of 13 were more than four times as likely to have any mood disorder (in the last 12-months) than women born in the US [74].

1.2.3.2 During migration

During migration, migrants often experience separation from loved ones and a loss of social support or networks, which have also been shown to be associated with an increased risk of psychological symptoms [47, 61, 62, 75-79], and identified as salient themes in qualitative research [2680]. In some cases this separation from loved ones is also associated with worry or fear for loved ones in their countries of origin, and studies have shown this to be associated with psychological symptoms as well [13, 81].

Migrants may also be exposed to other stressors during the process of migrating including extended time in transit between leaving the country of origin and arriving in the destination country, time in refugee camps or transit centres, exploitation or extortion, or violence, which have been shown to increase the risk of experiencing psychological symptoms [75, 82-87].

1.2.3.3 Post-migration

Migrants may also experience a range of stressors following migration (e.g. in destination countries) that impact on their mental health, or which exacerbate the effects of prior stressors.

Downward mobility

There is evidence that some migrants experience downward mobility or a loss of socio-economic status (e.g. due to language barriers, restrictions on their right to work, or a lack of transferability of qualifications), which has been shown to be associated with an increased risk of psychological symptoms [24, 47, 55, 88-90].

Isolation

Post-migration, migrants may also experience distance from their community or cultural group, a lack of social networks in the destination country, and barriers to integrating or

developing social networks. The resulting social isolation and lack of social support migrants experience has been shown to be associated with an increased risk of psychological symptoms [20, 47, 60-62, 75-79, 89, 91-95].

Marginalisation

Experiences of marginalisation (including social exclusion, discrimination, racism, and stigmatisation) following migration have also been shown to increase the risk of psychological symptoms for migrants [63, 89, 96-103], and may also contribute to their isolation and barriers to accessing services [104, 105]. Qualitative research has also identified that experiences of marginalisation and discrimination are significant themes, and can present barriers to help-seeking and the accessibility of resources (e.g. housing, social support, or health care) [104, 106-108]. For example, in qualitative interviews with 48 health care professionals in Europe, Sandhu et al identified that marginalisation due to migrants' language proficiency and their migrant status (e.g. being perceived as 'something different') resulted in barriers to utilising services, for example due to discriminatory practices. The professionals interviewed also described the multiple marginalisation migrants may face due to their limited socio-economic status, lack of social networks, or difficulties developing trust, in addition to language barriers, or experiences of discrimination and social exclusion [109].

Migrants' experiences of discrimination may be related to their legal status or ethnicity, and migrants may consequently experience multiple marginalisation or experiences of discrimination or oppression due to an intersection of these statuses [110, 111]. Research has also pointed to the concept of 'double jeopardy' for migrant populations in destination countries, where the risk of psychological symptoms is associated with both migrant status and ethnicity [112]. For example, in their cross-sectional survey of 7,345 elderly individuals in the US, Lum and Vanderaa found that migrants had higher levels of depression that native-born individuals, and that among migrant participants, those of black and Hispanic ethnicity experienced higher levels of depression compared with white migrants in the sample [112]. However, studies largely only examine isolated experiences of marginalisation, and fail to acknowledge experiences of marginalisation at multiple levels (e.g. by other individuals, their communities, or the state). There has also been little consideration of the implications of systemic marginalisation for health

or access to coping resources, or gender differences in experiences of marginalisation (e.g. due to the intersection of gender and other marginalised statuses).

Legal status

There are also several post-migration factors pertaining to legal status, including living in refugee camps, being detained, legal restrictions (e.g. on migrants' ability to work or access services), lengthy asylum processes and corresponding periods of uncertainty, insecure or temporary legal status or residency, and deportation, that have been found to be associated with an increased risk of psychological symptoms, as well as exposure to other stressors like violence, poor living conditions or deprivation, lack of access to health services, or feelings of powerlessness [20, 24, 31, 32, 60, 63, 87, 96, 113-124]. Legal status has also been identified to contribute to migrant women's exposure to abuse and barriers to leaving abusive situations, particularly for women without leave to remain or dependants. For example, in semi-structured interviews with thirty migrants with no recourse to public funds who had experienced domestic violence, Anitha identified that women's insecure legal status and lack of access to public funds presented significant barriers to leaving abusive situations, including fears of deportation, barriers to accessing support, exclusion from services, and financial insecurity [125]. This was also echoed in Wachholz et al's study using focus groups with 48 women who expressed a fear of reporting abuse (e.g. to police) because of their fears of being deported, and the barriers to leaving abusive relationships due to their legal status [126].

Authors have discussed the exclusion or marginalisation of migrant communities through state policies and the migration system, and in particular, the marginalising effects of the restrictions on access to public funds or the ability to work have been highlighted [107, 127, 128]. Migrants' experiences of marginalisation within the migration system have also been identified in studies using qualitative methods. For example, in in-depth interviews with 27 refugees and asylum seekers recruited from a traumatic stress clinic in London, Bögner et al identified that during Home Office interviews participants felt persecuted by the officials interviewing them, that they were treated like criminals, or that officials made it evident they did not believe them. In some cases participants also reported that they did not feel physically safe [129]. Findings relating to these experiences of marginalisation within the migration system have important

implications, particularly as asylum seekers' asylum applications are contingent on the disclosure of sensitive events to migration officials.

However, few studies look at gender differences in the marginalisation migrants experience because of their migrant status, and specifically the experience of having an insecure legal status.

Acculturation

Much of the research discusses the relationship between psychological symptoms and acculturation. Acculturation can be defined as the processes of assimilation, integration, and marginalisation, and the cultural and psychological changes that accompany this, during the period of settlement following migration [130]. This definition is broad, and acculturation is not consistently defined across the literature. Measures used for acculturation vary greatly across studies [48], and include time since migration, age at migration, language proficiency, social integration, cultural participation or identification, beliefs, experiences of discrimination or social exclusion, and sense of belonging [131]. The migrant populations included in studies examining the relationship between acculturation and psychological symptoms are also heterogeneous, for example in relation to their countries of origin or trajectory of migration, and in their exposure to stressful life events. In addition, gender differences exist in the effects of acculturation on psychological symptoms, which may further contribute to variations in findings across studies. For example, in their cross-sectional survey of 291 Greek Cypriot migrants in Camberwell (London), Mavreas and Bebbington identified that disorder was more prevalent in men with higher levels of acculturation and in women with the lowest levels of acculturation [132].

These factors make the relationship between acculturation and psychological symptoms difficult to assess. Consequently, there is inconsistent evidence in the research regarding the effect of acculturation on psychological symptoms [131, 133 97, 112, 133-139]. In much of the research, acculturation has been suggested to be inversely associated with psychological symptoms [72, 95, 131, 134, 140 76, 141], though studies have also identified that increased acculturation may be associated with poorer mental health [75, 131, 142-144]. Other studies have identified a non-linear trend (e.g. alternating increases and decreases in

psychological symptoms), inconsistent relationships across migrant groups, or an indirect or non-significant relationship [40, 131, 145-150].

The relationship between acculturation and psychological symptoms may be mediated by exposure to acculturation stressors (which may increase or decrease with time following migration depending on the context of migration). Such stressors include language barriers, or culture shock, culture conflict, or culture loss, which have been shown to be associated with psychological symptoms [94, 101, 135, 147, 151-155]. Migrants may also experience other 'living difficulties' or resettlement stressors including a loss of or low socio-economic status, barriers to employment, challenges finding stable accommodation, a lack of social resources, difficulties accessing health care or social services, or a lack of control, which may be associated with psychological symptoms and can persist regardless of acculturation, or even be exacerbated [21, 47, 54, 75, 89, 97, 134-139, 156].

1.2.4 Mental health of migrant women

Much of the research on migration and mental health does not examine gender differences. However, migrant women have been found to experience a higher prevalence of common mental disorders and PTSD than male migrants [15, 18, 24-29], and gender differences have been identified in the types of stressful life events migrants experience, and rates of exposure to stressful life events, which may contribute to differences in the prevalence of psychological symptoms between male and female migrants [10-12].

Violence against women is one of the most common stressful life events reported by migrant women [157], and research has identified very high rates of exposure to physical and sexual violence among some migrant women (e.g. asylum seeking or trafficked populations) [70, 71, 157-165]. For example, in interviews with 192 women and adolescent girls accessing post trafficking assistance in Europe, Zimmerman et al identified that 94.8% had experience physical or sexual violence [163]. Research has also reported that the prevalence of exposure to gender-based violence among refugee and asylum seeking women may be as high as 70% [160, 166].

Migrant women's increased risk of exposure to interpersonal and sexual violence may be due to the conditions surrounding migration; impunity surrounding violence or

abuse; subjection to violence (e.g. sexual violence) in exchange for documentation, passage, or other 'favours'; women's dependence socially and legally when migrating as dependants; immigration laws privileging male migrants; a loss of social networks isolating women from support resources; gendered barriers to help seeking (e.g. due to socio-cultural restrictions or requirements); or a loss of control or agency [28, 47, 157, 167, 168].

There is also evidence that migrant women are at increased risk of domestic violence, which is often initiated following migration [157]. Language difficulties, isolation from social support, culture conflict or changes in cultural identity, legal status, and structural changes in gender roles or power hierarchies following migration (e.g. in provider roles in the household) have been suggested to contribute to this increased risk of domestic violence for migrant women following migration [157, 169-172].

The prevalence of these forms of violence experienced by migrant women is difficult to measure, however, because of barriers to disclosure and underreporting [173]; thus women may experience even higher rates of exposure to violence than have been identified.

1.2.5 Conclusion

It is not clear whether migration is associated with an increased risk of psychological symptoms in women. This is partly because many studies on migration and mental health have failed to examine gender differences in psychological symptoms. In addition, gender differences in exposure to stressful life events, contextual factors (e.g. demographic characteristics, acculturation stressors), or protective factors have rarely been systematically investigated. This leads to the perpetuation of gender biases in research on migration and mental health [174]. Furthermore, there is limited research on differences in the risk of psychological symptoms or exposure to risk factors between migrant and non-migrant women. Consequently, there remains a gap in research on migrant women's mental health.

1.3 Review of research on mental health of migrants in the UK

Here, I will review the literature on the relationship between migration and psychological symptoms (including common mental disorders and PTSD) for communities in the UK, providing insight into the populations studied in this doctoral research.

1.3.1 Background

Migrant populations in the UK (and globally) are increasing, and migrant women may be at particularly increased risk of psychological symptoms compared to other populations. Poor mental health has the potential to both reduce women's quality of life and functioning, and to adversely affect their ability to pursue social, educational, or economic opportunities [14]. Consequently, insight into the mental health needs of migrant women in the UK is needed to inform policy and services.

In the UK, there are approximately 4.5 million foreign born migrants, and migrants comprise one-third of residents in London [175, 176]. In 2012, 515,000 individuals immigrated to the UK, of whom 439,000 were non-British citizens. Overall, there was a net flow of 163,000 migrants to the UK. 197,000 individuals migrating to the UK came for study, the most common reason for migrating to the UK. 173,000 individuals migrated for work, 68,000 came to join family members, and 11,713 individuals were granted visas as dependants joining or accompanying other migrants. 21,785 individuals applied for asylum (27,486 including dependents), of whom 6,065 individuals were granted asylum. There were also 8,172 asylum appeals from main applicants, 2,192 of which were allowed [177, 178]. Overall, slightly more men than women migrate to the UK annually. More men than women apply for visas as skilled or temporary workers annually, and 70% of main asylum applicants are men. However, 70% of dependant asylum applicants are women [176, 178]. The most common countries of origin of migrants in the UK are India (12%), China (8%), Pakistan (8%), Poland (6%), and Australia (5%) [177].

The migration (or legal) statuses of migrants in the UK include: UK Nationals, European Economic Area (EEA) Nationals, migrants with visas (study, work, dependant), asylum seekers, or migrants with Discretionary Leave to Remain or Indefinite Leave to Remain [179]. There is little data available on migrants entering or currently residing in the UK 'illegally'.

The migrant populations in the UK are diverse with regards to their socio-demographic and socio-economic characteristics, reasons for migration, migration trajectories, exposure to stressful life events, mental and physical health statuses, and their access to coping resources. Migrant communities require appropriate health services, and further

insight is needed into the specific health needs of these populations in the UK, and of migrant women in particular.

1.3.2 Aims

This review aims to identify and summarise primary research examining psychological symptoms experienced by migrants in the UK.

1.3.3 Methods

1.3.3.1 Selection criteria

1.3.3.1.1 Inclusion criteria

Papers were eligible for inclusion if they: 1) included migrants living in the UK aged 16 or older; 2) presented the results of primary research investigating the prevalence or risk (e.g. as measured in cross-sectional surveys, cohort studies, case control studies etc) or experience (as reported in studies with qualitative designs) of psychological symptoms (including anxiety, depression, PTSD, or related statuses or psychological symptoms (e.g. suicidal ideation, self-harm, somatisation, 'stress', 'psychological well-being', cultural idioms of distress, etc)); and 3) were published in peer-reviewed journals.

1.3.3.1.2 Exclusion criteria

Papers were not included in the review if they: 1) did not disaggregate data for migrants and individuals born in the UK; 2) included populations living in countries other than the UK and did not disaggregate mental health outcomes for populations in the UK; 3) did not disaggregate data for adults and children; 4) included other mental health outcomes (e.g. psychoses) or did not disaggregate data on psychological symptoms (common mental disorders or PTSD); or 5) were case studies, reviews, book chapters, reports, discussion papers, editorials, commentaries, letters, or conference proceedings.

1.3.3.2 Search strategy

Scope of the Review

This review includes all studies identified through the specified search strategy and which I deemed met the inclusion criteria.

Data Sources

Electronic databases relevant to mental health and social science research, including MEDLINE, PsycINFO, EMBASE, and Sociological Abstracts (CSA), were searched for papers published any date up until 29th April 2013. Eligible papers identified through hand-searching or cross-referencing were also included.

Search Terms

The search terms used for each included database, including keywords and relevant mesh headings, are listed in Appendix 1 (page 338). Search terms for migration were informed by several reviews [180, 181]. Search terms for psychological symptoms were informed by several reviews and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) [182-184]. Search terms used to identify research on populations in the UK were also informed by previous reviews [183, 185].

1.3.4 Results

1.3.4.1 Description of yielded papers

The search process and number of yielded papers is shown in Figure 1. A total of 61 papers were included in the final review. The papers included in the review were published between 1960 and 2012; there were few recent studies (only 24 of the 61 studies identified were published in the last decade). See Appendix 2, Table 32 (page 341) for a summary of all included papers.

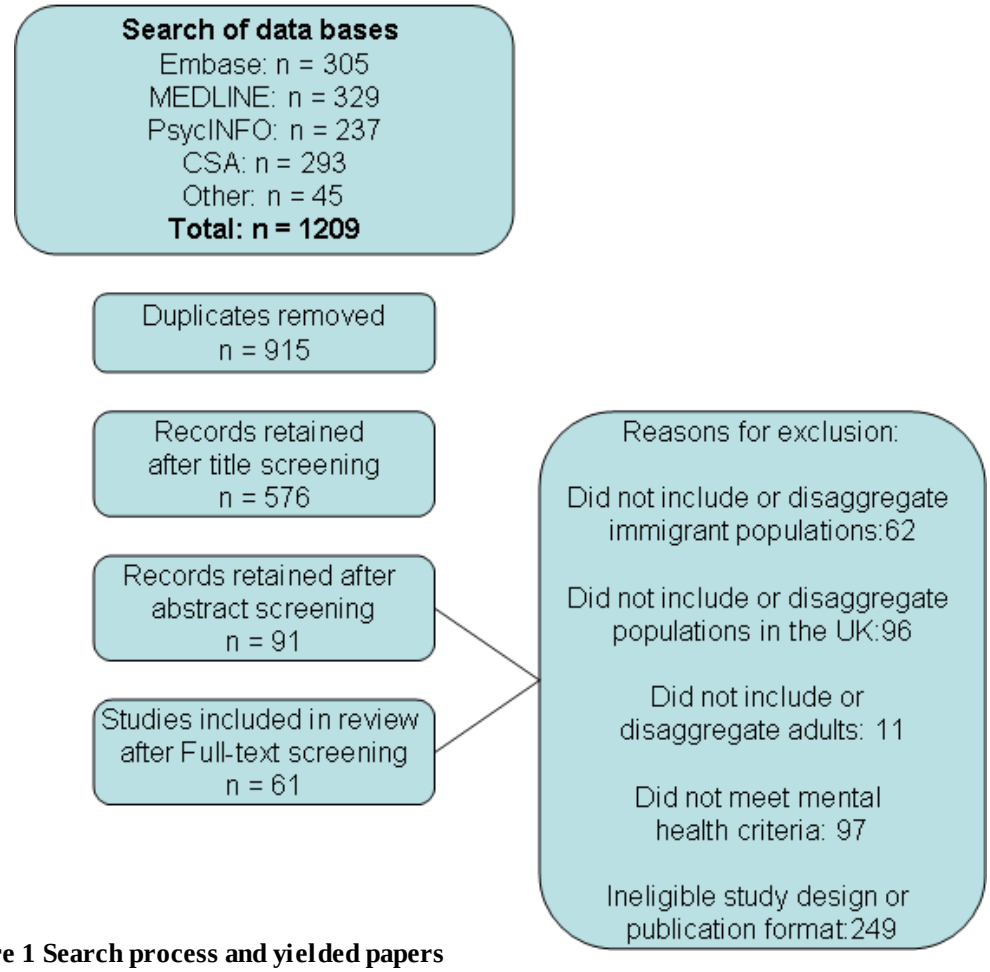

Figure 1 Search process and yielded papers

The studies identified were predominantly cross-sectional studies (n=39), but also included cohort studies (n=7) and two case-control studies. The range of sample sizes for these studies were: cross-sectional studies (27[186] to 186,000[187]), cohort studies (75[188] to 243[189]), and case-control studies (200[190] to 360[191]). Across the studies, the prevalence rates of any psychological disorder, depression, anxiety, and PTSD varied significantly. The prevalence rates across the studies that measured any psychological disorder ranged from 0.0% (measured among men from the West Indies using the Full Present State Examination [192]) to 70% (measured among migrants from Africa through clinical assessment [193]). The prevalence rates for depression ranged from 7% (measured among Kurdish asylum seekers through clinical assessment [194]) to 96% (among refugees, asylum seekers, and refused asylum seekers using the Hopkins symptom Checklist-25 [195]). Rates of anxiety ranged from 2% (measured among elderly individuals of Asian origin using the Geriatric Mental State Schedule [196]) to 73% (among asylum seekers who had previously been imprisoned in the UK for criminal offences, measured using the Hospital Anxiety and Depression scale [197]). Refugees and

asylum seekers were found to experience higher rates of psychological symptoms than other migrant groups in the included studies. This is also reflected in rates of PTSD, which ranged from 14% (among both Somalis measured using the Mini Neuropsychiatric Interview [198], and Kurdish asylum seekers through clinical assessment [194]) to 81% (among refugees, asylum seekers, and refused asylum seekers recruited from NHS trauma clinics, outpatient psychology services, and refugee support agencies, measured using the Hopkins Symptom Checklist [195]). The significant variation in the prevalence rates measured across studies reflects the range of measures used and populations included. Furthermore, underreporting or barriers to measuring psychological symptoms in migrant populations (e.g. diverse illness models, language barriers, stigma, etc) may also impact on study results.

Five studies used mixed-methods (both quantitative and qualitative methods). Nine other studies utilised qualitative methods. The sample sizes in the studies using qualitative methods ranged from 9[199] to 153[200]. In the qualitative studies, themes were identified relating to the stresses associated with stressful life events (e.g. trauma), bereavement or disconnection, stigma (surrounding mental health or stressful life events), isolation, loss of control, social exclusion and discrimination, fear of authorities and problems with the migration system, financial difficulties (including loss of socio-economic status, barriers to work, deprivation, and poor housing conditions), challenges associated with language, and barriers to receiving adequate care. Migrants also described the importance of social support as a coping resource, and the salience of social functioning and quality of life (not only mental health).

Across the studies using qualitative methods, a range of methods were used, which impacted on the comparability of findings. Studies collected data through focus groups, in-depth interviews, and ethnographic research, and used a range of analysis methods (including thematic analysis, interpretative phenomenological analysis, and content analysis). Across the qualitative studies, the cross-language methods used (e.g. for using interpreters or translators, or translation and analysis) were also inconsistent. Across all of the studies it should be noted that language impacted on who participated and the data generated; language barriers represent a methodological issue, and were not always adequately addressed to ensure bias did not result.

The majority of the included studies measured symptoms of depression, anxiety or PTSD. There was a wide range of instruments used, including the General Health Questionnaire (GHQ), the Women's Health Questionnaire (WHQ), the Personal Health Questionnaire (PHQ), the Comprehensive Assessment and Referral Evaluation (CARE), the Health of the Nation Outcome Scales (HoNOS), the Symptoms of Anxiety and Depression Scale (SAD), the State Trait Anxiety Inventory, the Present State Examination, the Schedule for Clinical Assessment in Neuropsychiatry (SCAN), the Hopkins Symptom Checklist (HSCL), the Brief Psychiatric Rating Schedule, the PTSD Symptom Scale Interview (PSS-I), the Schedule for Affective Disorders and Schizophrenia (SADS), the Peritraumatic Dissociative Experiences Questionnaire Self-Report Version (PDEQ-SRV), the Beck Depression Inventory (BDI), The Beck Anxiety Inventory (BAI), the Post-traumatic Diagnostic Scale (PDS), the Geriatric Mental State schedule (GMS-A), the Symptom Checklist-90 (SCL-90), the MINI Neuropsychiatric Interview, the Langner-22 Item Scale, the Hospital Anxiety and Depression Scale (HADS), Clinician Administered PTSD Scale, Edinburgh Postnatal Depression Scale (EPDS), the Impact of Event Scale (IES-R), and clinical assessment.

In addition to these psychiatric diagnostic categories, studies also looked at other health outcomes with symptoms or affects that are suggested to correspond to anxiety, depression, and PTSD, for example social functioning, suicidal ideation, self-harm, distress, psychological adjustment, psychological symptoms, and life satisfaction or well-being [103, 201-203]. The somatic presentation of psychological symptoms was also examined [189, 204-207].

Participants were recruited from patient records, clinical settings, the community, snowball sampling, and community organisations. Yielded papers included comparisons of psychological symptoms between migrant populations in the UK, and between migrant populations in the UK and native populations (either in the UK or in migrants' countries of origin) or migrant populations in other countries. Thirty of the studies included migrants in the UK and individuals born in the UK, though in six of the studies groups may not have been entirely disaggregated according to migrant status (e.g. individuals were categorised according to ethnicity and both migrants and non-migrants (e.g. first and second generation) may have been categorised in the same group). These studies were included as it was likely that the 'migrant' group was

predominantly comprised of first generation migrants to the UK. 25 studies only included migrant populations in the UK. Many of these studies were focused on specific types of migrants (e.g. refugees or asylum seekers) [194, 195, 198, 208-212], or on migrants from specific countries of origin [201, 204, 208, 213-216]. Ten of the studies that used qualitative methods focused on populations from specific regional backgrounds. These studies provided insight into risk factors, needs, or illness models specific to certain populations. For example in focus groups and semi-structured interviews with 19 migrants from the former Yugoslavia, Djuretic et al identified that participants focused on the impact of their experiences on their social functioning rather than on their emotional or psychological health [217].

There were a range of migrant populations examined in the research yielded in this review, including asylum seekers, refugees, trafficked populations, economic or labour migrants, and dependants. The migrant populations studied came from a range of countries, including India, Pakistan, Bangladesh, Somalia, China, Japan, Iraq, Iran, Turkey, Cyprus, Ireland, the former Yugoslavia, Poland, the Caribbean, and Hungary. Populations from South Asia were most well represented in the studies identified, included in 21 of the included studies, which reflects the representation of this population in the general population in the UK (see section 1.3.1, page 29). In addition, 15 studies included migrants from Africa, 6 included migrants from the Caribbean, 16 included migrants from Eastern or Central Europe, 8 included migrants from Western Europe, and 4 included populations from East Asia. Three studies categorised migrants from either Africa or the Caribbean together, not distinguishing country or origin of birth in their analyses [207, 218, 219]. Some populations (e.g. Latin American migrants) were underrepresented in the research. This may reflect the small numbers of these individuals in the UK, the more recent arrival of and lack of accumulation of research on certain communities, or an emphasis in research on other mental illnesses like psychosis (rather than common mental disorders or PTSD) in some populations (e.g. Caribbean).

One paper only included men [220], and ten studies included only women [188, 200, 202, 203, 214, 221-225], two of which included only populations of migrant women [214, 223]. Eighteen of the studies did not disaggregate the results by gender. Seventeen of the studies provided

data on both migrant women and women born in the UK, however only ten of these studies directly compared these two groups.

1.3.4.2 Psychological symptoms among migrant populations in the UK

There was inconsistent evidence in the papers reviewed regarding whether migrants were at increased risk of experiencing high levels of psychological symptoms. Nine studies either showed no significant association between migration and psychological symptoms or found inconsistent findings across migrant groups. For example, in a cross-sectional survey of 72 Somali and 75 Bengali first generation migrants, and 127 white individuals born in the UK, Silveira and Ebrahim identified that migration was not associated with anxiety and depression, after adjusting for age, income, physical health, and social problems [226].

Eight studies pointed to a higher risk of psychological symptoms among migrant populations compared to native populations in the UK or in migrants' countries of origin. For example, in a cross-sectional survey of 243 West Indian migrants registered at a GP practice in Birmingham and 682 British participants, Burke identified that West Indians experienced a higher incidence of depression than British individuals. West Indians were also found to be more likely to have a psychosomatic illness [189]. In a cross-sectional study of 1085 people aged 65 or older living in London, Livingston et al identified that migrants from Cyprus reported significantly more symptoms of depression than individuals born in the UK [218]. In a related study using the same sample, migrants born in Cyprus, Greece, or Turkey were found to experience a higher prevalence of depression than individuals born in the UK. These migrants were also found to experience the highest prevalence out of the other migrant groups included in the sample. However, overall (across all migrant groups) migration was not found to be associated with depression [207].

Nine studies suggested migrants were at decreased risk of experiencing psychological symptoms compared to non-migrants. For example, in a cross-sectional study of 50 migrants born in Pakistan, 50 migrants born in India, and 100 matched individuals born in the UK, Asian migrants were found to have lower levels of psychological symptoms compared to the native population [227].

1.3.4.3 Factors associated with psychological symptoms

There was a wide range of factors identified across the studies included in the review that may be associated with psychological symptoms for migrants in the UK. Here, I summarise the factors that were most consistently found to be associated with psychological symptoms in the literature reviewed, including socio-demographic characteristics, socio-economic status, physical health, exposure to stressful life events, migration specific factors, and protective factors.

1.3.4.3.1 Individual characteristics

The research described how statuses including gender, ethnicity, and socio-economic status contributed to the risk of experiencing high levels of psychological symptoms for migrants. However, studies often overlooked the intersection of multiple statuses, and the effects of multiple marginalisation on social and health needs, which both perpetuates assumptions that populations are homogenous (e.g. that the experience of a privileged majority population is equivalent to that of a marginalised population, ignoring social inequalities or oppression), and the reverse – assumptions of 'difference' (e.g. due to culture or ethnicity) whereby commonalities (e.g. shared socio-economic statuses) between groups of women are ignored, and certain groups are further marginalised or 'othered' [110, 111, 228-233].

1.3.4.3.1.1 Gender

Nine of the studies suggested that female migrants and native populations of women (in the UK or countries of origin) experienced higher rates of psychological symptoms than men. For example, in their cross-sectional survey of Asian migrants, Furnham and Shiekh identified that female migrants had significantly higher levels of psychological disturbance (measured using the Lagner-22 Item Scale) than male migrants [234]. In a cross-sectional survey of 611 White, 72 'Afro Caribbean' migrants, and 41 British 'Afro Caribbean' patients after their first admission in a psychiatric hospital in Birmingham, McGovern et al identified higher rates of admission for affective disorders among white women and Afro Caribbean women than white men and Afro Caribbean men [219]. However, this was not always the case. In a case-control study of Irish migrants recruited from general practices in North London, men were found to have significantly higher mean scores on both the Beck Depression Inventory and the Hospital Anxiety and Depression Scale than women [191].

Overall, eighteen of the studies reviewed did not disaggregate by gender, and consequently did not examine gender differences in the risk of psychological symptoms or exposure to risk factors. Additionally, only 10 studies tested to see if any difference in outcome or exposure to risk factors existed between migrant women and women born in the UK. Across the studies that did compare these groups, there was inconsistent evidence regarding whether migrant women were at increased risk of psychological symptoms compared to women born in the UK. Four studies found migrant women were at increased risk of psychological symptoms, two studies identified migrant women were at lower risk, and four studies did not find a significant difference in the risk of psychological symptoms between native women and migrant women.

1.3.4.3.1.2 Ethnicity

Ethnicity was determined according to linguistic group, religious group, region of origin, or ethnic group, and was often equated with migrant status in the studies. In thirteen studies, ethnicity was found to be significantly associated with psychological symptoms. However, there was inconsistent evidence regarding whether ethnic minority groups were at increased risk of psychological symptoms compared to individuals who identified as white.

Across studies looking at ethnicity, ethnic minorities were found to be at increased risk of psychological symptoms compared to majority populations (e.g. White populations in the UK) in five studies. For example, using data from the Millennium Cohort Study, including 17,258 mothers born in the UK and 2,327 mothers born outside the UK, Jayaweera and Quigley found that ethnicity was associated with depression regardless of migrant status (adjusted for length of residence, age, and education); mothers from 'other white', Indian, and Pakistani ethnic groups were found to be at increased risk of depression compared to white British/Irish mothers (after adjusting for country of birth, parity, age, education, occupational class, ward type, or being a lone parent) [235]. However, ethnic minority groups were found to be at decreased risk of psychological symptoms compared to white individuals in eight studies. In three studies there was no clear association between ethnicity and psychological symptoms, either because there was variation in risk across ethnic groups or because no significant association was identified. For example, in their cross-sectional survey of 282 Punjabi and British patients recruited from two health centres in Bradford, Krause et al identified that

ethnicity was not associated with psychological symptoms (measured using the General Health Questionnaire)[206].

1.3.4.3.1.3 Socio-economic status

Consistent with research in other migrant and non-migrant populations, an association was identified between socio-economic factors and psychological symptoms. For example, unemployment, low levels of education, poor living conditions, and financial stressors were typically found to be associated with an increased risk of experiencing psychological symptoms [198, 203, 204, 208, 226, 236]. However, the relationship between socio-economic status and psychological symptoms was not always consistent [72, 235]. For example, in their cross-sectional study of migrants from Pakistan and India, and individuals born in England, Cochrane and Stopes-Roe identified that social class gradient was negatively associated with psychological symptoms for individuals born in the UK, but not for Indian migrants. They identified that Indian migrants of a higher status experienced higher levels of psychological symptoms. This was particularly evident among Indian women [72]. However, there was a lack of other research investigating whether the relationship between socio-economic status and psychological symptoms differed between men and women, or whether the relationship between socio-economic status and psychological symptoms differed for migrant women and women born in the UK.

However, while the research showed that low socio-economic status may be associated with an increased risk of psychological symptoms, there is insufficient research examining how migrant status may contribute to poor socio-economic status, the marginalisation migrants consequently experience, and the effects of these factors on migrants' mental health. Furthermore, few studies examine women's specific experiences of socio-economic stressors (as compared to men), though their socio-economic status may be informed by their gender (e.g. gender differences in roles or social expectations, or their legal status, for example as dependants).

1.3.4.3.2 Physical health

Poor physical health was also found to be associated with an increased risk of psychological symptoms among migrants and native populations, which is consistent with research in other populations [200, 203, 220]. Some of the factors relating to physical

health were gender specific, for example pregnancy or menopause [200, 214]. For example, in their cross-sectional study of 153 peri and post-menopausal Asian migrant women, Caucasian women born in the UK, and Asian women in Delhi, India, Hunter et al identified that for women from Delhi, depressed mood was significantly associated with vasomotor symptoms, as was anxiety and depressed mood for Asian migrant women. Neither anxiety nor depressed mood were found to be significantly associated with vasomotor symptoms for UK Caucasian women. Overall, however, there was a lack of research examining differences in the effect of poor physical health on psychological symptoms for migrant women and women born in the UK, or among men and women.

1.3.4.3.3 Stressful life events

The studies included in this review consistently demonstrated that exposure to stressful life events was associated with an increased risk of psychological symptoms [186, 197, 208, 214, 215, 227, 237, 238]. In particular, the increased risk of psychological symptoms for depression, anxiety, and PTSD following exposure to traumatic events (including conflict, violence, or sexual abuse) was highlighted in the literature [186, 194, 195, 197, 208, 215, 236, 238, 239]. For example, in their cross-sectional survey of 180 Somali migrants in the UK, Bhui et al identified that pre-migration traumatic events (including shortages of food, exposure to conflict, being close to death, and serious injury) were associated with an increased risk of psychological symptoms. Furthermore, rates of anxiety and depression were found to increase in relation to the number of events experienced [208]. As in this study, the impact of exposure to trauma on psychological symptoms was predominantly investigated in refugee or asylum seeking populations, and typically, the exposure to trauma focused on in these studies occurred prior to migration [186, 197, 210, 236, 238].

Several studies identified gender differences in exposure stressful life events or their effects on psychological symptoms [210, 223, 227]. In a cross-sectional survey of 50 migrants born in Pakistan, 50 migrants born in India, and 100 matched individuals born in the UK, Cochrane and Stopes-Roe identified that crowding was associated with an increased risk of psychological symptoms (measured using the Langner-22 Item Scale) for Indian and Pakistani women, though not for men in these migrant groups [227]. In in-depth qualitative interviews with 25 Kurdish asylum seekers and refugees, Griffiths et al identified that there were differences in how stressful events were experienced in male

and female asylum seekers and refugees. For example, participants described that women had a 'more difficult time' because of responsibilities relating to child minding (e.g. during migration, in camps, etc), or feeling imprisoned at home following their migration to the UK [210]. In qualitative interviews with Asian migrant women, Wilson identified that women experienced gendered stressors, including not being allowed to work, or not being allowed out alone, which were associated with feelings of isolation and depression [223].

Across the studies reviewed, however, gender differences in exposure to stressful life events or the impact of stressful life events on psychological symptoms were typically not explored, particularly for exposure to trauma. While many studies had data to enable them to look at gender differences, surprisingly few did, though previous research suggests gender differences exist [10-12, 70, 71, 157, 158, 164, 165, 240-242]. Furthermore, there was a lack of research exploring whether differences existed in exposure to or the effects of stressful life events on psychological symptoms for migrant women and women born in the UK.

It was also surprising that few studies were focused on women's exposure to gender based violence (e.g. sexual violence or domestic violence) and its impact on psychological symptoms, though across research with migrant populations in other countries, there is a range of literature focused on these forms of violence and their effects. Exposure to abuse, for example, has consistently been found to increase the risk of experiencing high levels of psychological symptoms across populations of women [243-245], and qualitative research has found that women perceive that these types of abuse negatively affect their mental health and well-being [246-252]. Bögner et al did specifically look at the impact of exposure to sexual violence on refugees and asylum seekers and identified that individuals with a history of sexual violence were at increased risk of PTSD and of dissociative experiences. However, this sample only included 27 individuals, and they did not disaggregate by gender in these analyses [186].

It should be noted that there is literature exploring these factors in ethnic minority communities of women in the UK, but such studies do not disaggregate migrant from women born in the UK in the analyses and thus were not reviewed here.

1.3.4.3.4 Migration specific risk factors

In the studies reviewed, I identified a range of migration-specific risk factors occurring prior to, during, or following migration that were found to be associated with psychological symptoms.

One pre-migration factor explored in the literature was age at migration (which is also discussed in the context of acculturation in some research). In their cross-sectional survey of Indian migrants and individuals born in the UK, Cochrane and Stopes-Roe identified that being young at migration was associated with a decreased risk of psychological symptoms [72]. Unplanned or poorly planned migration was also found to increase the risk of depression [191].

There was a trend across the reviewed studies suggesting that asylum seeking or refugee populations are at increased risk of experiencing psychological symptoms compared to other migrant populations (which was often attributed to their increased exposure to trauma prior to migration). Consequently, 'reason for migration' was suggested to be associated with psychological symptoms in a number of studies [194, 195, 198, 208-212]. However, while 'reason for migration' may be described as a pre-migration factor, there are other stressors associated with this (e.g. insecure legal status, time in refugee camps or detention centres, or deportation), that occur during other stages of migration and may partly explain the increased risk of psychological symptoms experienced by these populations.

While stressors occurring during migration (for example control over the trajectory of migration, increased time in transit, time in refugee camps or transit centres, exploitation, or exposure to trauma) have been suggested to be associated with psychological symptoms in the literature on migrant populations [19, 75, 82-87], few papers identified in this review discussed risk factors experienced during migration for migrants in the UK. The paper that most explicitly described experiences during migration was a study using in-depth qualitative interviews with 25 Kurdish asylum seekers and refugees. In this study, participants highlighted traumatic experiences during their journey to Greece (prior to arriving in the UK), including dangerous conditions, destitution (e.g. lack of food, poor sanitation, overcrowding), time in refugee camps, strenuous travel, and the loss of loved ones, and how these experiences impacted on their mental health and well-being [210]. Several papers examined factors that could have occurred during migration, including exposure to trauma, loss of control,

detention, and loss of social support. However when these events were experienced was typically either not stated, or these events were discussed in the pre or post-migration context [195, 223, 236].

Post-migration stressors were discussed more extensively in the reviewed literature than stressors during other phases. Some of these stressors were particularly salient for certain migrant groups (e.g. example asylum seekers). For example, not having a permanent residence permit, or not being able to return to their countries of origin were identified to increase migrants' risk of psychological symptoms [197, 236]. Detention was also found to be associated with an increased risk of experiencing psychological symptoms (e.g. depression and anxiety) [197]. This is supported by other research [32, 253-255]; longer time in detention has been shown to be associated with higher levels of psychological symptoms (including distress or mental disturbance) [253, 255, 256].

Feelings of powerlessness or a lack of control following migration was also found to be associated with an increased risk of psychological symptoms in the literature [257]. Studies using qualitative methods have also identified the salience of powerlessness, and a lack of control or agency [220, 221, 258]. In their in-depth qualitative interviews with 15 Pakistani women in the UK being treated for depression, Gask et al identified that 'feeling stuck' (describing women's inability to escape family conflict or their feelings of depression), was a key theme relating to women's experiences of depression following migration [221]. In their in-depth qualitative interviews with Somali men, Silveira and Allebeck identified that low level of control over one's life and feelings of helplessness were perceived to be associated with depression following migration [220].

In the included studies, there was inconsistent evidence regarding the relationship between acculturation and psychological symptoms[72, 191, 227, 235]. Indicators of potential level of acculturation utilised in the reviewed studies included length of stay or time since migration to the UK, age at migration, language proficiency, and social integration. Social integration was suggested to be associated with a decreased risk of psychological symptoms [72], and was associated with an increased length of time in the UK. However, in their study using data from the Millennium Cohort Study, Jayaweera and Quigley identified that for migrant mothers, longer time in the UK was associated with an increased risk of depression (measured using the Malaise Inventory Sore for depression) [235].

There were also a number of stressors associated with acculturation or settlement that were found to be associated with an increased risk of psychological symptoms in the literature. In a cross-sectional study of 47 asylum seekers and refugees, Carswell et al identified that adaptation difficulties and a loss of culture were associated with an increased risk of psychological symptoms in the literature reviewed [195]. Culture conflict and resulting conflict with one's family or community was another acculturation stressor explored in the literature [259-261]. A few of the studies reviewed identified that culture conflict (or related stressors including marital difficulties or family conflict) was associated with an increased risk of psychological symptoms [204, 221, 262].

Language barriers were also found to be associated with an increased risk of psychological symptoms, partly because of the challenges they may present to integration or accessing services [33, 263-266]. This was supported by Furnham and Shiekh's cross-sectional survey of 100 Asian migrants in the UK, in which they identified that limited English language proficiency was associated with an increased risk of psychological symptoms [234].

Acculturation stressors relating to marginalisation or social exclusion were also identified. For example, in their cross-sectional survey of 854 war refugees from the former Yugoslavia, Bogic et al identified that not feeling accepted in the host country was associated with higher rates of mood and anxiety disorders [236]. Experiences of discrimination or racism (which may be associated with both ethnicity and migrant status) were found to be associated with higher levels of psychological symptoms [189, 220, 223], for example among Asian migrants experiencing racial prejudice or abuse [234].

Another post-migration factor that has been consistently identified across research on migration and mental health, and that is highlighted in the research on migrants in the UK, was a loss of social support or social networks, and experiences of isolation in the UK (including from their cultural communities, or due to social exclusion) [100, 195, 220, 221, 223, 226]. In their cross-sectional survey of refugees, asylum seekers, and failed asylum seekers, Carswell et al identified that a loss of culture or support was significantly associated with increased rates of emotional distress [195]. Social isolation and loneliness have also been identified as significant themes in qualitative research [100, 220, 221].

Overall, however, there was a lack of research examining gender differences in exposure to or the effects of migration specific factors.

1.3.4.3.5 Protective factors

Increased social support was found to be a protective resource in the literature [199, 220, 267]. For example, in in-depth qualitative interviews with Somali men, Silveira and Allebeck identified that family support or reliance on Somali peers were important sources of support and were protective against depression [220]. There were other social resources also described in the literature that were protective, including social integration, staying connected to culture, and talking about one's experiences [72, 199, 210]. Other coping resources discussed in the literature included religion, resisting or other strategies to increase control or agency, or escape or avoidance strategies [199, 220, 221]. Overall, however, few studies extensively investigated protective factors, or comprehensively discussed the intersecting processes that contribute to migrant women's need for these support resources, though migrants have identified that they perceive the challenges they face resulting in their need for social support to be interconnected [106]. Furthermore, there was a lack of research examining gender differences or differences between migrant women and women born in the UK in the use of, access to, or protective effects of coping resources.

1.4 Discussion

In the papers reviewed, there was inconsistent evidence regarding whether migrants are at increased risk of experiencing high levels of psychological symptoms compared to native populations. This may be attributed to the diversity of migrant populations included in the studies reviewed, with regards to socio-demographic and socio-economic characteristics, countries of origin, experiences of migration, exposure to stressful life events, and conceptualisations surrounding the causes and symptoms of illness.

Across the studies there was also variation in the methods used, measures of psychological symptoms, and definitions of migration. This may also have contributed to the discrepancies in findings, and may limit the comparability of studies. Some of the studies identified examining psychological symptoms among migrants in the UK were also limited by small sample sizes and language barriers (due to exclusion criteria

limiting the participation of migrants, or a lack of rigorous cross-language research methods). Furthermore, while there was a large number of studies evaluating psychological symptoms among migrants within a biomedical framework, few studies investigated other conceptualisations or illness models relating to mental health. The use of biomedical or Western diagnostic categories in research with migrant populations has been questioned, as these may not be universal, or may be unable to distinguish between normative distress and disorder in these populations [268-274].

In the literature, exposure to stressful life events, and traumatic events in particular, was found to increase the risk of psychological symptoms for migrants, in line with existing research. The literature reviewed suggested that female migrants were at increased risk of psychological symptoms compared to male migrants. However, overall in the papers reviewed, few studies examined gender differences in exposure to stressful life events, or their relationship with psychological symptoms. Furthermore, there was a lack of research examining differences between migrant women and women born in the UK in exposure to stressful life events or the risk of experiencing high levels of psychological symptoms.

It is evident from this review that there is a gap in research investigating gender differences in risk factors and psychological symptoms among migrant populations in the UK. Furthermore, there is a lack of research exploring differences in risk factors or psychological symptoms between migrant women and women born in the UK, and no consensus regarding whether migrant women are at increased risk of experiencing psychological symptoms compared to women born in the UK. In addition, few studies explored women's mental health or well-being using qualitative methods or culturally relevant conceptualisations of illness. Consequently, there is limited research on the perceptions of migrant women and women born in the UK regarding what experiences have impacted on their mental health or well-being, and how they have been affected.

As outlined below, this thesis aims to address the gaps in the research identified in this review.

1.5 Outline of thesis

This mixed-methods doctoral research aims to investigate the impact of migration and stressful life events on the mental health and well-being of migrant women and women born in the UK living in London.

In this study, the terms migrant and migrant are used interchangeably to refer to individuals who have emigrated from their country of birth to the UK.

Mixed-methods research may be particularly beneficial for research on the health of migrant populations as qualitative methods can explore the processes and contextual factors that may underlie the quantitative findings of associations between mental health and migrant status [275-277]. Furthermore, using a combination of methods may be helpful in addressing issues in research with migrant populations such as language, the heterogeneity of migrant populations, and diverse illness models or conceptualisations of illness.

In chapter 2, I specifically focus on a methodological issue that is key to research with migrant populations: the migrant women included in this study came from range of linguistic backgrounds and it was important to acknowledge and address language barriers that might occur due to this diversity. While rigorous methods for using translation in research using quantitative methods (e.g. cross-sectional surveys using standardised questionnaires) have been identified, there is no consensus on valid cross-language methods in qualitative research. In this chapter, I review the literature on cross-language qualitative research methods, and synthesise recommendations in this literature to identify methodological guidelines. These guidelines informed the use of cross-language methods in my qualitative interviews.

In chapters 3 and 4 I present a study investigating the impact of migration and stressful life events on psychological symptoms for women in London using data from a cross-sectional survey, the South East London Community Health Study (SELCoH Study). In chapter 3, I investigate whether first generation migrant women are at increased risk of experiencing high levels of psychological symptoms compared to women born in the UK. In chapter 4 I conduct two exploratory analyses to gain more insight into the relationship between psychological symptoms and macro and individual level migration specific factors.

In chapters 5-7 I present the results of a thematic analysis of in-depth qualitative interviews with migrant women and women born in the UK. This study aimed to investigate what experiences women perceive have impacted on their mental health and well-being, how they have been affected, and how these experiences and women's conceptualisations of mental health and well-being differ for migrant women and women born in the UK. This aims to address gaps in research exploring individual level experience or 'insider experience' [278].

In chapter 8, I discuss the implications of the study findings, and present recommendations for policy, services, and future research.

1.5.1 Study aims and objectives

The main aims of this doctoral research are to:

- Carry out a review of cross-language qualitative research methods, and synthesise recommendations to identify methodological guidelines (chapter 2);
- Investigate the relationship between migration and psychological symptoms for women living in London (chapters 3 and 4);
- Identify what experiences women perceive have impacted on their mental health and well-being, how they have been affected, and how these experiences and women's conceptualisations of mental health and well-being differ for migrant women and women born in the UK (chapters 5-7).

The specific objectives of this doctoral research are to:

- Carry out a review of literature on cross-language qualitative research methods to synthesise recommendations and identify methodological guidelines using a framework approach (chapter 2);
- Investigate whether first generation migrant women are significantly more likely to experience high levels of psychological symptoms than women born in the UK, after controlling for confounders, including stressful life events using cross-sectional data (chapter 3);

- Using data from a cross-sectional survey (the SELCoH Study), explore differences in the risk of experiencing high levels of psychological symptoms between first generation migrant women and women born in the UK due to macro-level factors (chapter 4);

- Using data from a cross-sectional survey (the SELCoH Study), explore how individual level migration specific factors contribute to differences in risk across migrant women (chapter 4);

- Through a thematic analysis of in-depth qualitative interviews with first generation migrant women and women born in the UK, identify what experiences women perceive have impacted on their mental health and well-being, how they have been affected, and how these experiences and women's conceptualisations of mental health and well-being differ for migrant women and women born in the UK (chapters 5-7).

Chapter 2: Review of Cross-Language Qualitative Research Methods

2.1 Introduction

Globally, communities are becoming increasingly multi-cultural and multi-linguistic [279-281]. For example, approximately 4.5 million migrants aged 16 and over live in the UK, and approximately 11% of residents in the UK are from another country of origin [175, 176]. These migrant and ethnic minority populations ultimately require appropriate and accessible health services. Furthermore, research is needed to inform services of these populations' needs. Such research needs to be representative of these populations, regardless of their linguistic or cultural backgrounds, and valid. However, the representativeness and validity of research can be compromised when methodological issues surrounding cross-language research are not adequately addressed [282]. In order to investigate the needs of populations with diverse linguistic backgrounds, rigorous cross-language methods are therefore needed [283, 284]. However, while guidelines for cross-language methods in quantitative research have been identified, there is a gap in the literature on rigorous cross-language qualitative research methods. This study aims to identify methodological recommendations for conducting cross-language qualitative research.

2.1.1 Background

Qualitative research enables a study to investigate an individual's perspective and experience, and can ultimately provide insight into the complexity, detail, and context of a populations' needs [285, 286]. However, there are no established methodological guidelines for conducting rigorous qualitative research with populations with diverse linguistic backgrounds, for example migrant or ethnic minority communities. The majority of literature utilising or discussing cross-language research relates to quantitative research. Methods of addressing language barriers have been identified and validated for quantitative research, and methods to achieve equivalence (e.g. back-translation) have been established [286]. However, very little research has been done into how the trustworthiness of qualitative research is affected by language, or what methods can improve trustworthiness in cross-language qualitative research [286-289]. Furthermore, in cross-language qualitative research, methodological issues relating to the use of

translation or the impact of cross-language methods on the study results are rarely sufficiently discussed [282, 285, 290]. This compromises the transparency of research.

Differences in linguistic and cultural background can present significant barriers to determining the needs and perspectives of diverse populations [286]. For example, migrants or ethnic minorities who are not native speakers of the language of the host country or the language used by researchers or health providers may not receive adequate care or be represented in research.

Research shows that patients are more likely to ask questions regarding their care or mental health, and rate the quality of the care they receive as higher when language barriers are addressed (e.g. through the provision of interpreters) [291]. Furthermore, language barriers have been shown to reduce the reporting of traumatic experiences or resulting psychological symptoms, which can result in decreased referrals to psychological care [264].

Language barriers also compromise the representativeness of research. Participants who do not speak the language in which the research is conducted (e.g. non-English speaking participants) are often excluded, either due to studies' exclusion criteria, or because of methodological challenges (e.g. lack of appropriate cross-language methods like use of interpreters or translated recruitment material) [292]. While the ease and feasibility of research is a necessary logistical consideration, such constraints often mean migrant or ethnic minority communities are not adequately represented [287, 290, 293, 294], which can result in an unethical bias [293]. Even when such populations are included in research, language barriers can impact on the trustworthiness or validity of the data generated [284, 291].

Language is a methodological issue; the barriers presented by cultural and linguistic differences have logistic and analytic implications for qualitative research [286]. I therefore aimed to review the recommendations presented in the literature for conducting and improving the trustworthiness of cross-language qualitative research, and identify methodological guidelines to inform the cross-language qualitative research I conducted in this PhD (see chapters 5-7).

2.1.2 Definitions

Cross-language research occurs when language differences are present between participants, researchers, and the intended audience for the results [282]. While the terms translator and interpreter are often used interchangeably, the two can also be distinguished [282, 290]. A *translator* can be defined as an individual who translates information in written form between languages. Written translation can apply to interview questions, information sheets or consent forms, recruitment literature, transcribed interviews or other data in written form, or the dissemination of research findings [282, 295]. An *interpreter* can be defined as an individual who deals with oral translations of material, which can include interpretation of interviews or focus groups, as well as audio recordings or videos [282, 295]. Interpretation may also be necessary beyond oral translation, including for non-verbal communication including body or sign language [288, 296].

2.1.3 Objectives

The specific objectives of this study are to:

1) Identify papers reviewing or discussing cross-language qualitative research methods;

2) Identify and synthesise methodological recommendations in the literature using a framework approach to establish methodological guidelines for conducting cross-language qualitative research.

2.2 Methods

2.2.1 Search Strategy

The databases PsycINFO, EMBASE classic + EMBASE, MEDLINE, and CSA (Sociological Abstracts) were searched for papers published in peer-reviewed journals up until August 13th, 2013 that either reviewed literature on conducting cross-language qualitative research, or discussed cross-language qualitative research methods, and issues of validity or trustworthiness. Papers presenting primary qualitative research that did not discuss methodological recommendations for or methodological issues relating to cross-language qualitative research were not included.

The following combination of free-text keywords was searched for in the included databases for all dates: [‘qualitative’ *or* ‘nurs* method*’ *or* ‘nurs* research’] *and* [‘interpreter*’ *or* ‘translator*’ *or* ‘cross-language’] *and* [‘review’ *or* ‘method*’] *and*

['valid*' *or* 'trustworth*']. For CSA, these terms were searched for 'anywhere' in the articles in the subject area 'social sciences'. Terms including translat* or interpret* were not used because they yielded results which were not relevant to cross-language research. Bibliographies from yielded papers were cross-referenced to identify additional relevant papers. Eligible papers identified through hand-searching or cross-referencing were included.

2.2.2 Analysis

I identified and extracted methodological recommendations for conducting cross-language qualitative research or improving validity or trustworthiness in the included papers. These recommendations were synthesised using a deductive framework approach [297] to determine methodological guidelines for conducting cross-language qualitative research. The methodological recommendations extracted from the text were organised ('indexed') according to which stages of qualitative research they applied, and the type of method described (e.g. relating to written translation, oral interpretation, etc). An analytical framework was then developed through which the categories to which the extracted recommendations pertained identified through the indexing process were clearly defined. The analytical framework was then applied through indexing the recommendations in relation to the defined categories. Recommendations were summarised and 'charted' in this framework. This systematic approach to the analysis contributed to the reliability of the analysis and the systematic identification of cross-language qualitative methods described in the literature [297]. In addition, the recommendations identified in the papers and the analysis process and development of the framework were discussed with my supervisors, which also contributed to the trustworthiness of the analysis. Following this analysis I produced methodological guidelines for cross-language qualitative research. These guidelines reflect my interpretation of which recommendations identified in the literature are most essential for ensuring the quality and rigour of cross-language qualitative research.

2.3 Findings

2.3.1 Literature Search

A total of 34 papers were included in this review. Eleven papers were identified through the database search. The search in PsychINFO, EMBASE classic + EMBASE,

and MEDLINE yielded 68 results. After excluding duplicates (24), nine of these papers were identified to be relevant to this literature review. The search in CSA yielded 32 papers (excluding duplicates). Of these, four were found to be relevant, two of which had already been identified in the previous database searches. An additional 23 papers were found to be relevant to this review through cross-referencing the bibliographies and hand-searching the literature. (See Figure 2).

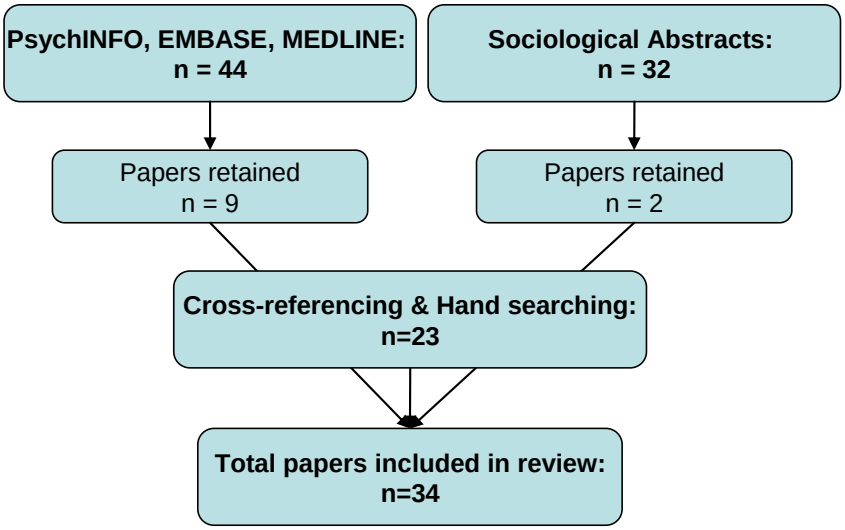

Figure 2 Papers yielded in review on cross-language qualitative research methods

2.3.2 Methodological recommendations for cross-language qualitative research

The methodological recommendations identified in the included papers related to four themes: 1) the background of translators or interpreters; 2) the development and translation of written materials; 3) data collection; and 4) the management, analysis, and dissemination of data. The included papers and methodological recommendations are described in Table 1.

Table 1 Cross -language methodological recommendations of included studies (n=34)

Background of translators or interpreters	Development and translation of written materials	Data Collection	Management, analysis, and dissemination of data
(Almalik, 2010)[298]			
• Match demographic characteristics and cultural background of interpreter with participant. • Use bilingual translators from same country as participant. *Comments: Matching has limitations (e.g. participant may anticipate judgment if from shared background as interpreter, and thus may not speak openly; in small communities, participants and interpreters may be known to each other or others discussed, and participants may fear anonymity/ confidentiality may be compromised). Background of interpreter should be informed by participant's preferences.*	• Use independent bilingual translator for back-translation of interview materials. • Compare back-translations of interview materials with original versions. • Have interviewers read English copy of interview guide to verify acceptability to participants. *Comments: Back-translation may not be appropriate if emphasis of translation is on conceptual equivalence rather than semantic equivalence, and if material being back-translated is not standardised.*	<u>Prior to interviewing:</u> • Discuss research with interpreter prior to the interview including the: aim/purpose of interview, topic guide, interpreter's role, and confidentiality of study. <u>During the interview:</u> • Use concurrent interpretation (e.g. translation occurs during interview).	• Use bilingual researcher to re-interpret interviews from recordings, as if in interview; record re-interpretation. • When multiple translations of transcripts exist, compare them to determine discrepancies.
(Baird, 2011)[299]			
• Interpreters act as cultural brokers. • Cultural congruence between interpreters and participants. • Training and experience of translators and interpreters. *Comments: May be limitations to cultural congruence between interpreters and participants (see*			

limitations of matching above).			
(Bradby, 2002)[300]			
	• Appropriate language should be used so is locally comprehensible. • Inform wording of questionnaire based on language of target group. • Use triangulation in translation: use multiple translators and independent reviewer. • Review translated research questions prior to use and amend if needed. *Comments: Language of written materials and in which interview is conducted should be determined by research aims, participant preferences; should not be assumed that this language must be native language of participants.*		• Interpreter actively participative. • Reflexivity.
(Chen, 2009)[289]			
• Translator should be bilingual and culturally knowledgeable; back-translators should also be bilingual.	• Equivalence of meaning (conceptual equivalence) in translations; translator should aim to achieve equivalence in structure and format, also considering cultural nuances. • Conduct back-translations for established content, including instruments, to achieve semantic	• Discuss translations with translators to ensure conceptual equivalence is achieved. • No 'wrong' translations.	• Transcribe interviews in original language. • Conduct analysis in source language and translate the analysed data. • Content analysis recommended for cross-language research. • Back-translate translated codes to

	equivalence. • To validate translations, use two translators and conduct an independent bilingual review of translation. • Can discuss translations with translators, expert panel or bilingual committee to achieve conceptual equivalence or review translated material. *Comments: May be limitations to back-translation (see above).*		improve accuracy. • Translate concepts/themes with two bilingual translators and agree on final translated version (use independent bilingual translator to back-translate concepts to original language).
(Edwards, 1998)[301]			
• Match interpreter and participant and interpreter and researcher. • Interpreter as 'key informant' (provide cultural and linguistic knowledge). • Interpreters can be used throughout research in question including writing study design, data collection, and analysis. *Comments: There are limitations to matching (see above).*	• Interview interpreters about what issues they perceive surrounding research questions, and translations.	• Have translations done in third person.	• Interview translators about their background. • Researchers should reflect on how interpreters impact data collection and research generally. • Interpreter's role should be made explicit in publications, be reflected on; make interpreters visible; say work 'with' rather than 'use' interpreter.
(Esposito, 2001)[287]			
• Validity can be improved by using professional credentialed interpreters; evaluate a sample of their work prior to the study.	• Use meaning-based translation, not word for word translations; translation should include connotations and contextual meaning.	• If primary researcher does not speak participant's language, use real-time and instantaneous (concurrent) interpretation so researcher can adjust data	• Compare independently translated transcripts. • Back-translate transcription to original or test for comprehension, naturalness, and readability using

	• Translated instruments need language level equivalent to source language. • Triangulate data (e.g. use two translators). • Seek help of people in community of participants/ target language speakers to identify appropriate dialect for translations. • Pilot test translated instruments.	collection. • Use appropriate dialect for participant in interviews. • Language used should be respectful (e.g. use of formal tense) and acceptable. *Comments: Use of interpreter (e.g. need for translation in interview) should be determined by participants' preferences and research aims.*	independent bilingual researchers. • Content analysis appropriate for cross-language data. • Have results validated by reviewers from participants' community. • Discuss translation methods, issues of translation, and challenges in publications. *Comments: Limitations to back-translation (see above).*
(Irvine, 2007)[302]			
		• Conduct data collection in original language where possible. • Familiarise interpreter with questions prior to interview. • Use same interpreter for all interviews. • Use concurrent translation. • Discuss interview with interpreter following interview. *Comments: Whether or not data collection occurs in a participant's original language should be determined by participant's preferences as well as research aims.*	• Conduct analysis in original language where possible, or transcribe interviews in original language, then translate transcription. • Have independent reviewer compare transcriptions to verify accuracy. • Content analysis appropriate method for cross-language data.
(Jagosh, 2009)[283]			
	• Consider language context – use ecological model of		• Incorporate translators throughout study (including analysis);

	translation. • Pilot interview materials; ask participants for feedback on materials following pilot.		• Researchers should engage in active reflexivity, including their own cultural and linguistic backgrounds and that of the translator(s) to improve trustworthiness.
(Kapborg, 2002)[288]			
• Match gender of interpreter, researcher, and participants. • Culture of interpreter and participant should be the same. • Interpreter should be bilingual and native speaker of participant's language. •Interpreter should be 'properly trained'. • Validity can be improved if researcher immersed in culture. *Comments: Limitations to matching (see above).*		• Use interpreter in interviews to overcome language and culture barriers. • Discuss interpreter's role with them prior to interview. • Use same interpreter for all interviews. • Priority should be meaning, not linguistic structure. • Interpreter should express verbal and non-verbal communication. *Comments: Language of interview (and use of interpreters) should be determined by participant's preferences and research aims.*	• Accurately describe procedure. • Discuss credibility of findings. • Discuss background of all involved in results.
(Larkin, 2007)[303]			
• Interpreter as analyst, cultural broker, and translator.	• Seek cohesion, congruence, clarity, and courtesy in translations. • Develop topic guide then translate. • Make topic guide succinct/comprehensive. • Use a multilingual team in	• Meet with translator prior to study to explain purpose of study and qualitative research. • Language creates meaning and word (semantic) equivalence flawed approach. • Interview in participant's native	• Transcribe interviews verbatim; translate transcription. • In analysis, compare within and between languages. • Discuss background of translators. • Translation methods used at all

	translating to enhance conceptual equivalence. • Attain two independent translations of topic guide and agree on final version through discussion. • For studies using multiple foreign languages, discuss final questions across languages to achieve 'global conceptual equivalence'. • Have final questions in topic guide assessed by independent reviewer. • Pre-test the interview.	language. *Comments: Use of language in interview should be determined by participant's preferences and aim of interview (shouldn't be assumed that interview should be conducted in participant's native language).*	stages of a study should be discussed.
(Marshall, 1994)[304]			
• Researcher should have knowledge of cultural background to understand responses.	• Use simple grammatical constructions. • Attention to nuances of language and socio-cultural context important in translating.	• Observe participant's non-verbal behaviour for cues of non-comprehension, etc. • Use probing to validate meaning of words used by participants (in semi-structured interview). • Assess responses for appropriateness and compensate for misunderstandings within the interview. • Replace words that aren't adequately understood with simpler or more appropriate terms during interview. • If sentence not understood, change key words within same basic sentences structure to aid	• Use field notes about context of interview to enrich data collected.

		comprehension and to avoid embarrassing subjects and decreasing their confidence.	
(Merry, 2011)[305]			
• Verify that interpreters and interviewers do not know the participants. • Match gender, country, ethnic/religious background. • Avoid using interpreters from participants' communities. *Comments: While I would also recommend that interpreters are not known to participants, this should potentially be informed by participant's preferences.* *Limitations to matching (see above).*	• Use feedback from interdisciplinary team when developing interview guide/data collection plan. • Community feedback on interview guide from 'ethno-cultural liaison group' (focus group with community representatives with linguistic, ethnic migration background similar to migrants). • Translate interview guide. *Comments: Translation of interview guide should be determined by need for interpretation in interview and method of interpreting.*	• Interpreters should review interview guide to ensure their understanding of and comfort with interview questions. • Use simple language, short phrases; explain terms not easily understood. • Obtain feedback from interpreters to supplement data.	
(Murray, 2001)[284]			
• Interpreters as 'gatekeepers' or 'cultural guides'. • Interpreter should be familiar with qualitative research generally, and the topic being studied. • Interpreter should be proficient in both languages used (participants' and researcher's). • In deciding characteristics of		• Use participants' own language and include an interpreter when needed. • Discuss purpose of interview, the interpreter's role, ethical issues, interpreting strategy with interpreter prior to interview; ensure interpreter is aware of confidentiality of data. • Concurrent translation;	• Can have independent translators verify validity of interpretations in interviews.

interpreter, base on participants' preferences.		interpreter may guide interview if provided list of topic areas, questions, etc – this improves flow; for sensitive topics or unexpected issues in interviews, interpreter should refer to researcher. • Translate in third person in interviews. • Discuss research with interpreters; allow them to provide suggestions/critiques informed by their cultural competence, and their perceptions or reflections about the interview. *Comments: Language used in interview should be determined by aims of research and participant's preferences; should not be assumed that participant's own language is preferable.*	
(Ojeda, 2011)[306]			
• Interdisciplinary group of researchers (including bilingual and bicultural, with knowledge of migrant issues or diverse migrant backgrounds). • Community advisory board for research.	• Conceptual equivalence (concepts have same meaning). • Back-translation to ensure meaning isn't lost. • Pilot interview with members of the target group ('cultural experts' or 'insiders') *Comments: There are limitations to back-translation (see above).*		• Reflexivity by research team.

(Pernice, 1994)[307]			
• Researcher should be bilingual.	• Use validated instrument or conduct back-translation. • Use emic etic approach in translation to use concepts from within culture with concepts imposed by researchers. *Comments: Use of validated instruments may be impractical for semi-structured in-depth interviews.* *Limitations to use of back-translation (see above).*	• Inform interpreter of aims of research. • In interviews, interpreter should use third person pronoun appropriate to social status of person; must use respectful version of language.	
(Pitchforth, 2005)[308]			
• Interpreter should be culturally similar to participants. *Comments: Limitations to having interpreter be culturally similar to participants (see above regarding limitations of matching).*		• Have discussion with interpreter prior to interview. • Reflect on interviews with interpreter. • Use same interpreter for interviews and transcriptions. *Comments: There are limitations to using the same interpreter for interviews and transcriptions (e.g. this does not enable the data to be validated or triangulated by an independent reviewer).*	• Compare transcriptions. • Be reflexive.
(Sechrest, 1972)[309]			
• Use interpreters/translators with good acquaintance with language	• Ensure translations are in language appropriate to		• Triangulation.

used by participants.	participant. • When translating, be aware of idioms and translate meaning, rather than verbatim; select terms which reflect meaning and nuance of original words; try to achieve similar level of idiom use in languages so one is not more formal, academic than other. • Use cultural translation or seek experiential equivalence where translations describe things experienced in both cultures; seek conceptual equivalence where meaning of concepts is equivalent across languages. • Achieve validity of translation within social systems, rather than across, so tools produce equivalent results within each context. • Try to keep length of translated materials similar in length to originals. • 'De-centreing' by discussing development of materials with individuals from both cultures can improve ability to achieve equivalence in translation. • Back-translation can be used, but pre-testing necessary. *Comments: "Language*		

	appropriate to participant" should be informed by participant's preferences. *Limitations to back-translation (see above).*		
(Shklarov, 2007)[310]			
• Interpreter should have role as researcher; integrate interpreter into research process.	• Identify etic and emic terms and focus on 'fit' between concepts rather than equivalency. • Cultural and contextual interpretation part of translating meaning.	• Interpreter should articulate ideas and subtle meanings to avoid misunderstandings.	• Reflection or self-evaluation by researchers and interpreter important.
(Squires, 2008)[295]			
• Use bilingual translators/interpreters; should have sociolinguistic competence (e.g. complex level of language competence with ability to express cultural meaning of words) and socio-cultural competence. • Use professional credentialed interpreters, or if not possible, a bilingual native speaker from same country of origin as participant. *Comments: Limitations to use of interpreter from same country of origin as participant (but this may be second best option for high level of socio-linguistic competence if processional credentialed interpreters are not available).*	• Write questions as simply as possible. • Translate topic guide after finalisation of questions. • Use independent bilingual consultant to review translation; if researcher does translations, should be checked by well-educated native speaker. •Use single translator for all written translations in a study. • Pilot translated research questions. • For studies using multiple foreign languages, can develop translation lexicon to achieve conceptual equivalence (this should be developed by	•Use language of participant. • Interpreter should also evaluate if topic guide questions represent meaning/construct of concept in participant's culture. • Interpreter should provide cultural/interpretive insights in translations. • Discuss with interpreters what happened in data collection. *Comments: Language used in interview should be informed by aims of study and participant's preferences.*	• Translator/interpreter part of process of data production; interpreter's background/characteristics influence their translations. • Validate data by discussing data with interpreters. • Phenomenological study not appropriate for cross-language research.

	researchers and translators).		
(Squires, 2009)[282]			
• Use of qualified bilingual translators/interpreters recommended (ideally with professional certification). • Interpreters/translators should be bicultural and bilingual (e.g. have knowledge of language structure/communication patterns) or have socio-cultural and sociolinguistic competence (e.g. can use complex sentence structures, have a high level of vocabulary, can describe concepts or words when they don't know actual translation.	• Back-translation of instruments advantageous. • Develop translation lexicon for studies using multiple foreign languages to improve conceptual equivalence. • Independent review by qualified bilingual individual recommended to validate accuracy of translation to enhance rigor. • Pilot translated interview guide prior to study. *Comments: Limitations to back-translation (see above).*	• Conceptual equivalence (translation of concepts, incorporating subject matter knowledge and local contextual knowledge). • Independent review of translated data.	• Narrative analysis one appropriate method for cross-language data. • Translator impacts on data generated (e.g. is a producer of data) and consequently on results.
(Suh, 2009)[311]			
• Researchers should have cultural knowledge ('cultural competence') of participant group. • Research team/interpreters should include individuals who share same ethnic culture as participants. • Recommended that researchers or interpreters with personal relationships with participants be included (to increase trust). • Trained interviewers are preferable. *Comments: Limitations to using interpreters from same cultural/ethnic*		• Interviews should be conducted in native language of participants. • Account for context so implied meaning of words is understood/interpreted. *Comments: Language of interviews should be informed by participant's preferences and aims of research; should not be assumed that should be in native language of participants.*	• Transcribe and code data in original language (then translate during analysis); compare meaning between languages during categorisation of codes. • Use bilingual and bicultural researcher to code transcripts in origin language. • Involve bilingual bicultural researchers in interpreting, translation, and analysis. • Source data and translated data should be compared to improve validity.

background or who are familiar to participant (e.g. may limit disclosure in interviews or compromise confidentiality/anonymity – see above).			
(Temple, 1997)[312]			
	• Discuss differences in versions of translations with translators (e.g. to reach a consensus on translation) to improve validity of translations.		• Researcher should examine background, experiences, perspectives of all involved in research ('intellectual autobiography/biography'). • Use field notes about context of interview to enrich data collected. • Make translator/interpreter visible.
(Temple, 2002)[313]			
			• Discuss 'intellectual autobiographies' with researchers/translators/interpreters to determine their backgrounds. • Recognise perspective of translator. • Translators should be made more visible. • Impact of interpreters/ translators on research should be considered.
(Temple, 2005)[293]			
			• Interpreters/translators actively involved in research; their contributions should be acknowledged. • Discuss differences in meaning across languages.

(Temple, 2008)[314]			
	• Back-translation may not acknowledge complexities.		• Reflexivity of researchers and participants
(Temple & Edwards, 2008)[315]			
• Interpreters as 'key informants'.	• Must translate concepts, context, or 'cultural meaning', not just words.	• Speak with interpreters and translators about their perspectives in the research.	• Discuss influence of translators or interpreters on research. • Reflexivity. • Make interpreters visible.
(Temple, 2006)[316]			
• Translators/ interpreters serve as 'key informants'.	• Confirm translations through discussions to achieve transfer of meaning.	• Train interpreter before interview and debrief afterwards.	• Learn about background of interpreter to reflect on how production of data could have been influenced.
(Temple, 2004)[296]			
	• Include context, not only words, in translations.	• Discuss translators' perspectives on data, transcription, issues in research.	
(Tsai, 2004)[286]			
• Use research team including individuals with varying ethnicities, language competencies.			• Translate recordings in original language to English orally onto audio-tape. • Have transcriptions of English recordings reviewed by bilingual interviewers. • Have coders with knowledge of languages and cultures; coders from same ethnic group as participants can help contextualise data. • Discuss codes with coders. • Phenomenology not an appropriate

			analysis method for cross-language data. • Consider researcher's social world frame of reference.
(Twinn, 1997)[294]			
		• Interview in native language of participant. • Use one interpreter for all interviews. *Comments: Language of interview should be informed by aims of research and participant's preferences (should not assume should be in native language of participant).*	• Triangulate transcription (e.g. have transcription done by independent translator). • Phenomenological analysis problematic. • Triangulate analysis; e.g. compare themes from original and translated data. • Describe background of all involved in study.
(Wallin, 2006)[290]			
• Improve cultural competence in analysis by using a diverse research team including members from participants' communities, or include individuals with similar language and culture of participants. •Matching of demographic characteristics may be beneficial depending on purpose of interview and participant's wishes. • Depending on the research and participant's wishes, interpreter may be known to participant or may be a stranger.		• Use one interpreter to increase consistency of interpretations and dependability of data. <u>Prior to interview</u> • Meet with interpreter before interviewing to discuss aim of research and their role. • Discuss questions with researcher/interpreter and standardise interpreting. <u>During interview</u> • Meaning should have priority over form; interpretation may involve interpretation of cultural meaning, not just language.	• Interpreter's knowledge can be used in analysis. • Triangulation should be used throughout the study to increase validity. • State in methods section of report: interviews *with* an interpreter, not *through*. • Interpreter should be made visible in dissemination of research; describe involvement of interpreters throughout study and their background.

		• Interpreter can act as key informant to help interpret cultural meaning. • Use third person in interpretations to demonstrate participants are communicating through interpreter. <u>Following interview</u> • Evaluate interview with interpreter following interview. • Interview interpreters and document their thoughts on the research.	
(Watkins-Mathys, 2006)[317]			
• Cross-national research team. • Develop research project collaboratively with research team (including interpreters); develop data collection protocol.		• Use interpreter and note-taker in interviews (focus groups) (aids in understanding cultural dimensions, non-verbal communication). • Data from focus group, and also from researchers, interpreters, and note-takers. • Check meanings during focus group with all involved in focus group session. • Discuss findings/observations with interpreter and note-taker after focus group; discuss and clarify notes etc.	• Check data before writing up with those with local knowledge. • After writing up results, check understanding of meaning with research team.
(Welch, 2006)[318]			
• Including interpreter as project collaborator (e.g. trained in qualitative	• Structured interview guide with frequent prompts, less complex	• Enabling participants to express themselves in own language may	

research and interview techniques; close working relationship with researcher) may improve accuracy/authenticity.	questions. • Avoid using idioms, dialect, colloquialisms in English.	improve authenticity; may also improve rapport. • Ask frequent clarifying questions. • Use multiple informants or other methods (e.g. observation). • 'Contextualisation resources' help to provide context for sense-making. *Comments: Language of interview should be guided by participant's preferences and aims of research.*	
(Williamson, 2011)[319]			
		• Interpreter-facilitated interviews. • Preparatory sessions for interpreters (emphasise not sanitising responses). • Have interpreters work with an English speaking research team member (rather than conducting interviews on their own). • Verify validity of data throughout data generation process (don't use interpreter summaries as sole source of data, for example have another member of research team review recorded interactions between interpreter and participants to supplement interpreter's verbal summaries).	

2.3.2.1 Background of translators and interpreters

It was recommended in the literature that the research team should be multicultural, and include individuals with a knowledge of the cultural background or native language of participants [286, 288, 290, 304, 306, 311, 317]. This may include a primary researcher with a socio-linguistic or socio-cultural knowledge of the research group, researchers who have been immersed in the relevant community, a community advisory board, translators or interpreters, or the members of the participant group (e.g. in line with community based participatory research methods [320]).

In seven papers, it was specifically recommended that translators or interpreters should have a role as researchers; they should be involved not only in the translation of material and data collection, but where possible, also throughout the research process (e.g. in the study design and analysis) [283, 290, 293, 295, 303, 310, 311]. This was encouraged to improve the trustworthiness of research, as well as to increase their visibility in the research. Translators' and interpreters' backgrounds influence their participation in the research and ultimately impact on the results of a study [282]. Consequently, in the literature, specifications for translators' or interpreters' backgrounds were stipulated in order to improve the quality of data generated and increase the validity of the study.

It was recommended that interpreters or translators are culturally and linguistically knowledgeable about the participant group [282, 286, 289, 290, 295, 298, 303, 308, 309, 311]. Translators and interpreters should have a minimum sociolinguistic and socio-cultural competence, e.g. be able to adequately speak the participant's language including familiarity with their dialect or particular idioms, an ability to use complex grammatical structures, have a high level of vocabulary, be able to describe concepts they encounter for which they do not know exact translations or nuances in meaning, and be able to provide cultural context in translations [282, 295, 304]. Three papers also recommended that translators and interpreters hold professional certification [282, 287, 295]. When credentialed translators or interpreters cannot be used, papers recommended that the translator or interpreter has some training and experience in translating/interpreting [288, 299], or be a native speaker of the participants' language and from their country of origin [288, 295]. In addition, it was also recommended that interpreters be familiar with qualitative research methods and the topic being studied [284, 318].

Papers also discussed recommendations for the demographic characteristics of interpreters, informed by the background of the study participants. Seven papers recommended selecting interpreters who shared certain demographic or cultural characteristics with the participant group (also called 'matching') [288, 290, 298, 299, 301, 305, 311]. Characteristics cited in the literature which may be particularly beneficial to match are native language [295], gender [288, 305], culture (e.g. ethnic or religious background) [288, 299, 305, 308, 311], and country of origin [298, 305]. For example, working with a female interpreter may be particularly beneficial for research with women, particularly in relation to sensitive topics, or an interpreter with a shared cultural-background to the participant may be able to provide more insight into culture specific topics.

However, working with interpreters who have similar characteristics or backgrounds to participants may also present barriers, for example participants may anticipate judgment in relation to certain topics from an interpreter who has a shared cultural or religious background, and thus may not feel they are able to speak openly. In in-depth interviews with 21 asylum seekers and refugees engaged with a refugee centre in London, Palmer and Ward identified that service users did not like using interpreters from their countries of origin or same cultural background, as they believed they would be judged or become the subject of gossip [321]. While this approach should in part be informed by the research aims and logistical considerations, it should also be guided by the preferences of the participant [284, 290].

One paper recommend that the participant be familiar with the interpreter [311]. While it is suggested that this may benefit the research because participants may feel more comfortable working with the interpreter, there are also limitations to this. For example, the participant may fear that their anonymity or the confidentiality of the research may be compromised, or that they cannot speak as freely because of their existing relationship with this individual. They may also not provide as much detail in their narratives if the interpreter is familiar with their background or experiences. Due to these limitations, there was also literature strongly recommending against the interpreter or interviewer being previously known to the participant or from their same community, and the importance of verifying this prior to the interview [305]. Ultimately, this should also be informed by both the research and the participants' preferences [290].

2.3.2.2 Development of written materials prior to data collection

It is recommended that written research materials are developed in collaboration with individuals with socio-linguistic and socio-cultural knowledge of the participant groups (which may include translators, community members, or participants themselves) [301, 305, 306, 309, 317, 318, 322]. This helps to improve the acceptability of the content of these materials, as well as the wording used, which may help to achieve accuracy in translations [322]. Prior to translation, wording (e.g. final questions in the topic guide) can also be independently assessed by individuals with socio-linguistic and socio-cultural competence to ensure they are succinct and acceptable for the research aims and the participant group [295, 303]. Written materials requiring translation should be finalised prior to translating [295, 322]; materials should be concise and simplified as much as possible, while retaining meaning, so that culture specific terms/colloquialisms and nuances in meaning are reduced, allowing for more accurate and comprehensive translations [295, 303-305, 318, 322].

The literature also recommends developing a translation lexicon for semi-structured interviews, especially when multiple foreign languages are included in a study, which enables translation to be more trustworthy within and across languages [282, 295]. Consistency is also improved if final questions or concepts are discussed across languages, and if translations have been standardised across languages for the key topics being discussed [322]. This ensures the same concepts are communicated to participants in interviews across languages, and improves the accuracy of translations [282, 295]. As discussed above, it is recommended that these materials are developed with and translated by individuals who have a knowledge of the language, relevant culture, and communication patterns of the participants [289, 303, 311 295].

There are a range of written materials that may require translation prior to data collection, including topic guides, recruitment literature, information sheets, and consent forms. The need to translate these materials should be informed by the needs of the participant group, for example the language they would prefer such literature in, as well as other factors like their literacy. Where, for example, participants have limited literacy and require that these materials are accessible in another language, the materials will need to be orally interpreted for them. In order to determine if translation is needed, and the appropriate language/dialect of translations, participants or individuals with socio-linguistic competence relevant to the participant group can be consulted [287].

In qualitative research, the translation of meaning ('conceptual equivalence') is recommended rather than word for word or verbatim translations ('semantic equivalence') [282, 283, 285, 287-290, 295, 296, 303, 304, 306, 307, 309-311, 315], as it is suggested to enable more accurate translations. Seeking conceptual equivalence requires that translations are informed by cultural and linguistic knowledge relevant to the participant group [300]. Translations should also use appropriate language for the target population (including dialect, language structure, politeness, cohesiveness, and acceptability) [284, 287, 300, 303, 309, 322, 323], and be similar to the original texts in format and structure (e.g. in length and language style) [287, 289, 309].

There are a range of methods recommended in the literature for improving the validity and acceptability of translations. Seven papers suggest back-translation as a method of establishing the trustworthiness of a translation [282, 287, 289, 298, 306, 307, 323]. In this method, the translated text is translated back into its original language and the original text and the back-translated text are compared to determine discrepancies [298]. Two papers specifically recommend that an independent translator be used for back-translation to improve validity, and to evaluate linguistic equivalence, comprehension, naturalness, and readability [287, 298, 287]. However, back-translation assumes a more positivist approach to translation, and is typically more appropriate for standardised questionnaires and for translations emphasising semantic equivalence or verbatim translation [289]. However, if conceptual equivalence is emphasised rather than semantic equivalence (which is recommended for semi-structured interviews for example), then the discrepancies yielded through back-translation may not be indicative of incorrect translation, but rather the various ways meaning can be expressed. Furthermore, back-translation may not be able to acknowledge the complexities in the material being translated [314].

There were other methods for improving the validity of translations discussed in the literature. In her review, Squires recommends that the same translator is used for all initial translations (in each language) to achieve consistency [295]. Other papers recommended using two or more independent translators for each translation [287, 289, 300, 322], and comparing all versions of translations for discrepancies, including source data and translated data [298, 311, 312]. Using an independent reviewer to evaluate the validity of translations is also recommended [282, 289, 294, 295, 298, 300, 303, 322]. Translated topic guides

can also be discussed with or reviewed by individuals with socio-linguistic knowledge relevant to participants, with members of the target community, or with others involved in the research (e.g. interpreters) in order to determine discrepancies in translations and amendments to improve the trustworthiness, appropriateness, and comprehensibility of translated materials [283, 287, 289, 295, 298, 300, 301, 303, 309, 312, 316]. This can also help to achieve equivalence across languages (especially if more than one target language is being included in a study) [303]. The methods used to improve the validity or trustworthiness of translations should in part be informed by what is feasible (e.g. given time and resources). However, it is important that translated research materials are checked at some stage by an independent reviewer with socio-linguistic and socio-cultural competence. This can also occur during piloting.

Prior to using written translated materials with participants, it is recommended they are piloted or tested with individuals with a socio-linguistic and socio-cultural knowledge of the participant group, and ideally with individuals from the group being researched [282, 283, 287, 295, 303, 306, 310, 322]. The participants in these pilot interviews can also be asked for feedback on the materials used (e.g. the topic guide) following piloting to inform any amendments [283].

2.3.2.3 Data Collection

2.3.2.3.1 Prior to the interview

Prior to the interview, the language in which the interview will be conducted and whether an interpreter is needed should be determined (e.g. by consulting participants). Using an interpreter in interviews can help to overcome linguistic and cultural barriers [288]. Furthermore, ten papers asserted that the authenticity and validity of the research is improved by using the native language of the participant when conducting research with participants who do not share the same first language as the researcher [284, 291, 294, 295, 302-304, 311, 318, 322]. Where the interviews are conducted in the participant's native language, it is important that the appropriate dialect is used, and that the language used is respectful (e.g. formality) and acceptable [287, 323].

Rather than assuming the language should be conducted in the native language of the participant, however, I would recommend that the language used in interviews be guided by the preferences of the participant (e.g. whether they prefer to conduct the

interview in their native language or the language of the host country). This is in line with recommendations that other factors (e.g. the background of the interpreter, the familiarity of the participant with the interpreter, or the use of recording) be determined by participants' preferences [284, 290, 311]. It is appropriate to ascertain a participant's preferences for the language of the interview as the participant may feel more comfortable discussing certain concepts in a non-native language (e.g. biomedical terminology which they may not have used or which may not be directly translatable to their native language) or feel a sense of pride in conducting the interview in a non-native language (e.g. the language of the host country). Furthermore, there are limitations to the use of interpretation, and there is no consensus in the literature that data generated by a participant in a non-native language is less valid than data generated in their native language and subsequently translated.

Where interpretation is needed, it is recommended that the researcher discuss the research with the interpreter prior to the interview [284, 288, 290, 305, 308, 319, 322]. This includes discussing: the aim of the research and the purpose of the interview [284, 290, 298, 303, 322, 323]; the interpreting methods, and the interpreter's role in the research [284, 290, 298, 319]; the interview guide to familiarise the interpreter with the interview questions, verify the topic guide's acceptability or validate it (if it has been translated), and standardise the interpreting [284, 290, 295, 298, 302, 305]; the confidentiality of the research and other ethical issues [284, 298]; and any additional training the interpreter may require [316].

2.3.2.3.2 During the interview

There are two predominant methods of conducting cross-language interviews discussed in the literature. The first is to use an interpreter trained in qualitative research or a bilingual researcher to independently conduct the interviews in the participant's language [289] (no translation would occur during the interview). The second is for the researcher to work with an interpreter who provides concurrent translation during the interview [284, 287, 295, 298, 302, 307, 319]. This is recommended where the primary researcher does not speak the participant's language, and may be preferable to the first method, as it enables an experienced researcher to adjust data collection (e.g. probe, seek clarifications, assess the appropriateness of responses, manage the interview if sensitive topics or unexpected issues arise, etc) [284, 287, 304, 319]. The literature recommends that the

same interpreter is involved in all interviews conducted in each language in the study to increase the consistency and trustworthiness of interpretations [288, 290, 294, 302, 308].

As for the translation of research materials, papers recommended that conceptual equivalence, rather than semantic equivalence or verbatim translations, is emphasised in the interpreting [288, 290, 309-311, 322]. This is pragmatic for semi-structured qualitative interviews. Furthermore, it enables the translator to provide culturally informed translations to achieve an accurate translation of meaning and overcome cultural and linguistic barriers [289, 290, 303, 310, 316]. While such translating does not require verbatim translations, it still requires the translator to be precise, and achieve a translation as close as possible to the original meaning of the participant, including in structure, format, and cultural concepts [289, 298]. The interpreter may also need to express both verbal and non-verbal communication (sign or body language) to achieve conceptual equivalence [288]. To improve the quality of translation in interviews, probing and verbally validating statements with participants in interviews is also recommended where necessary [284, 304, 317]. The appropriateness of participants' responses to interview questions (e.g. the trustworthiness of the translation of interview questions or participants' responses) can also be assessed in the interview setting in order to clarify questions or responses. However, this can also be assessed by listening to the recording or reviewing the transcript after an interview [298, 304].

Four papers specifically recommend interpreting in the third person [284, 290, 301, 323]. This approach makes the role of the interpreter more visible, and also clearly indicates in the translation that the participants were speaking through the translator, rather than implying the translation represents what participants said verbatim.

2.3.2.3.3 After the interview

In order to provide further insight into the meaning expressed in the interviews, and to improve the accuracy and trustworthiness of the translations provided, the literature recommends that the researcher discuss the interview with the interpreter following its completion [284, 285, 289, 290, 295, 301, 302, 305, 308, 312, 315-317]. This discussion allows the interpreter to supplement their translations with additional interpretations or cultural knowledge, and to provide suggestions or critiques for the research informed by their linguistic and cultural knowledge [284]. Discussing the interview with the interpreter also allows the researcher to gain the interpreter's reflections on the interview and what

occurred in data collection. This can be valuable for field notes (which can enrich the data [312, 317]), as well as for evaluating the interview and refining the interview questions or structure [290, 304, 308, 315]. The researcher can also discuss the interpreter's background (which influences their participation and the data generated) with them at this point [316, 324]. This process of reflexivity by gaining and documenting the interpreter's perspective on the research not only acknowledges their active role in the research and data production, but also increases the validity of the data (see section 2.3.2.4.3, page 81 for more on reflexivity).

2.3.2.4 Management, analysis, and dissemination of data

2.3.2.4.1 Management

Where interviews have been recorded, there are multiple methods for transcribing the data. Where concurrent interpreting occurred in the interview, either the translated data or both the translated data and the original language data may be transcribed. Original language data (including interviews conducted by a bilingual researcher or with concurrent interpreting) can be transcribed and then translated (either before or after coding; see below) [289, 302, 311, 322], or interpreted into the source language during transcription (e.g. translating orally onto audio-tape then transcribing, or translating data directly as it is transcribed) [286, 294].

Whether translation occurs in the interview, during transcription, or following transcription, it is recommended that an independent individual with socio-linguistic and socio-cultural competence validate the translated data [282, 284, 286, 287, 298, 302, 319]. Data can be validated by having an independent researcher review or re-interpret interviews from recordings [298, 319], by comparing the original and translated transcriptions [298, 302], or by comparing two or more independently translated transcripts [287]. Transcriptions can also be back-translated, or tested for comprehensibility, naturalness, and readability by an independent bilingual reviewer to improve trustworthiness [287]. Twinn also recommended that transcription should be done by an independent translator (e.g. not the original interpreter) to increase the trustworthiness of the data [294]. However, Pitchforth et al recommended that the same translator is used for interviews and transcriptions [308]. I do not feel this is advisable as using an independent interpreter or transcriber enables the interview data to be validated.

2.3.2.4.2 Analysis

The literature recommends that analysis involve individuals who are familiar with the language and culture of the participants, who can provide cultural knowledge and context to analysis [286, 290]. For example, nine of the papers recommended that the translators involved at earlier stages of the research have roles throughout the research process, including in the analysis [283, 290, 293, 295, 301, 303, 310, 311, 322]. Using multiple coders (particularly an independent coder with socio-cultural and socio-linguistic competence) to analyse the data can also increase the validity of analysis. It may also be beneficial to discuss the codes or final results with individuals or a team who can provide cultural and linguistic knowledge relevant to the participant group [286, 287, 317].

Few papers discussed methodological issues relating to methods of analysing cross-language data. Content, narrative, and thematic analysis were all recommended as appropriate methods for analysing cross-language data [282, 287, 289, 300, 302]. None of the papers reviewed recommend phenomenological analysis methods, and three explicitly cited that phenomenological analysis is not appropriate for cross-language research as the participants' words and experiences are being interpreted through a translator, and thus their individual phenomenological experience cannot be directly analysed [286, 294, 295].

There is no agreement in the literature regarding whether it is preferable to conduct analysis on translated data or data in the original language (e.g. translation occurring following analysis). Nearly all of the papers discuss translation prior to analysis (though this is often assumed, and not explicitly recommended). However, three papers recommend conducting analysis in the original language where possible, and only translating analysed data or codes [289, 302, 311]. Where analysis is conducted in the original language followed by translation, back-translation (using an independent translator) is recommended to improve trustworthiness [289] (though there are limitations to back-translation as discussed above). Triangulating translated codes is also recommended to improve trustworthiness [290], for example having two translators translate codes/themes, and compare their translations in order to achieve consensus on the translation of codes [289]. It was also recommended that data are compared within and between languages during analysis [322], for example analysing both the original and

translated versions of the text, and comparing the results [289, 294, 303, 311], or comparing the results across multiple languages.

2.3.2.4.3 Dissemination

The use of translation is a methodological issue, and thus should be discussed in the dissemination of cross-language research. All cross-language methods used should be explicitly and accurately described [287, 288, 296, 322] (and ideally mentioned in both the abstract and methods sections of papers), including challenges or limitations of the methods used and the credibility of findings [288, 296]. Translators and interpreters should also be made visible in the research [290, 312, 315, 324]. Two papers recommend that in the presentation of findings, it should be stated that the study was done 'with' interpreters and translators, rather than 'through' or 'using' them in order to make their active contribution to the research process more visible [290, 301].

In order to improve the trustworthiness of a study, researchers should engage in active reflexivity, including reflecting on translators' and interpreters' active and subjective involvement in the production of data, how their cultural and linguistic background (as well as the background of other researchers involved in the research) may have impacted on the study findings, and interpreters' perspectives on the research [290, 303, 313, 316 282, 283, 286, 288, 290, 294-296, 300, 301, 306, 308, 309, 312, 314-316, 322, 324]. In order to gain sufficient insight into interpreters' or translators' backgrounds, it may be necessary to discuss this with them (e.g. following the interview) (see section 2.3.2.3.3, page 78) [301, 316].

2.4 Discussion

2.4.1 Summary of methodological guidelines for cross-language qualitative research

The literature was reviewed to identify recommendations for cross-language qualitative research methods. These recommendations were synthesised to determine methodological guidelines for conducting cross-language qualitative research (see Table 2). Here I present these guidelines, which are my interpretation of which of the recommendations identified in the literature are most essential for ensuring the quality and rigour of cross-language qualitative research.

Table 2 Methodological guidelines for cross-language qualitative research

Background of translators and interpreters	*Development and translation of written materials*	*Data Collection*	*Management, analysis, and dissemination of data*
• **Involve translators and interpreters throughout the research where possible.** • **Interpreter or translator should have socio-cultural and socio-linguistic competence.** • **Use professional credentialed translators for translating and interpreting;** may also be beneficial if translators/interpreters are familiar with qualitative research methods or the topic being researched**.** • **Background of interpreter should be determined by participant's preferences as well as aims of research** (e.g. matching of characteristics, familiarity with participant, etc.).	• **Translation of written materials should be guided by participants' preferences and their literacy;** need for translation of topic guide should also be based on language preferences of participant, as well as type of interpreting used. •**Translate meaning (conceptual equivalence).** • **Research materials should be developed in collaboration with individuals with socio-linguistic and socio-cultural knowledge of participant group.** • **Develop a translation lexicon for studies using multiple foreign languages;** discuss final translations across languages to achieve 'global conceptual equivalence'. • **Use the same translator for each language included;** two translators can be used for each language if desired to triangulate translations.	<u>Prior to the interview</u> • **Identify participants' language (and dialect) of preference for interviews;** • **Discuss the research with the interpreter prior to interviewing (including purpose of the interview, interpreting methods, interpreter's role, interview guide, confidentiality, needed training).** <u>During the interview</u> •**If translation in interview is needed, either use bilingual researcher or concurrent translation** (the latter is preferable where interpreter does not have background in qualitative research)**.** • **Use the same interpreter for all interviews in each language.** •**Translate meaning (conceptual equivalence).** • **Interpretation in third person to**	<u>Management</u> • **Independent individual with socio-linguistic and socio-cultural competence should validate the translated or transcribed data.** <u>Analysis</u> • **Analysis can be conducted on original language data or translated data;** can increase reliability by analysing original language data and translated data and comparing codes. • **Analysis should involve individuals with socio-linguistic or socio-cultural competence (e.g. translators/interpreters).** • **Validity can be increased by using multiple coders (particularly individuals with socio-linguistic and socio-cultural competence) or discussing analysis with individuals who can provide cultural and linguistic knowledge**

	• **Use an independent reviewer with socio-linguistic and socio-cultural competence to validate translations.** •**Pilot topic guide and research materials.**	**make interpreter visible.** <u>After the interview</u> • **Discuss the interview with the interpreter afterwards (interpreter can supplement translations, reflect on the research, and interpreter's background can be discussed).**	**of the participant group.** • **Content, narrative, or thematic analysis appropriate for analysis of translated data; phenomenological approach not appropriate.** <u>Dissemination</u> • **Explicitly describe all cross-language methodologies used and justify choice of methods;** should state use of cross-language methods in abstract and methods sections of papers. • **Discuss methodological issues and limitations relating to use of cross-language methods.** • **Make interpreters and translators visible/role of interpreters explicit in the research (**e.g. describe involvement of translators/interpreters, state worked 'with' interpreters)**.** • **Engage in active reflexivity (e.g. discuss background and impact of all involved in research).**

2.4.1.1 Background of translators and interpreters

Translators and interpreters should be involved throughout the research process, where possible [283, 290, 293, 295, 303, 310, 311]. They should have a socio-linguistic and socio-cultural knowledge relevant to the participant group (e.g. be able to adequately speak the participant's language including familiarity with their dialect or particular idioms, an ability to use complex grammatical structures, have a high level of vocabulary, be able to describe concepts they encounter for which they do not known exact translations or nuances in meaning, and be able to provide cultural context in translations) [282, 295, 304]. Translators and interpreters, where possible, should also have professional certification [282, 287, 295]. If this isn't feasible, they should have some training or experience in translating or interpreting [288, 299]. It may also be beneficial for the translator or interpreter to be familiar with qualitative research methods or the topic being researched [284, 318].

The background of interpreters should be determined not only by the aims of the research, but (perhaps more importantly) by the preferences of the participant [284, 290]. This is also true for the familiarity of the participant with the interpreter, though I would typically discourage this as it may inhibit the participant's ability to speak openly, or compromise the anonymity and confidentiality of the interview [290].

2.4.1.2 Development and translation of written materials

Research materials should be developed, where possible, in collaboration with individuals with socio-linguistic and socio-cultural competence relevant to the participant group, for example translators or interpreters, community members, or participants themselves [301, 305, 306, 309, 317, 318, 322]. The translation of study literature should be guided by whether or not participants desire that written materials are translated (and what language they would prefer them to be translated into), as well as participants' literacy. Additionally, the translation of the topic guide should be determined by participants' preferences for the language in which the interview is conducted, and the type of interpreting being used. For example, if the primary researcher is working with an interpreter who conducts concurrent translation in the interview, the topic guide may not need to be translated (though the translation of key

words or concepts should be standardised prior to the interview if the topic guide is not translated).

Where written materials are translated, it is suggested that conceptual equivalence is emphasised (rather than semantic equivalence) [282, 283, 285, 287-290, 295, 296, 303, 304, 306, 307, 309-311, 315]. For each language included in a study, the same translator(s) should be used for each language [295]; two translators can be used for each language if desired to improve the validity of translations [287, 289, 300, 322]. Where translation is needed for multiple foreign languages in a study, a translation lexicon can be developed and translations can be discussed across languages to improve consistency in translations [282, 295, 322].

Independent individuals with socio-linguistic and socio-cultural competence should be used to review and validate the translation of written materials [282, 283, 287, 289, 294, 295, 298, 300, 301, 303, 309, 312, 316, 322]. Prior to using translated research materials with participants, they should also be piloted with individuals with a socio-linguistic and socio-cultural knowledge of the participant group, and ideally with individuals from the participant group [282, 283, 287, 295, 303, 306, 310, 322].

2.4.1.3 Data Collection

Prior to the interview the participant's preferences for the language of the interview, and consequently if an interpreter is needed, should be determined. Where an interpreter is needed, the researcher should discuss the research with the interpreter prior to conducting the interview, including the purpose of the interview, interpreting methods, the interpreter's role, confidentiality and other ethical issues, and any training needs the interpreter may have [94, 298, 300, 315, 318, 329, 330]. Additionally, the interview guide can be discussed with the interpreter in order to familiarise the interpreter with the interview questions, verify the topic guide's acceptability or the validity of the translation, and standardise the interpreting [284, 290, 295, 298, 302, 305].

When it is identified that an interview will not be conducted in the language of the primary researcher, a bilingual researcher can conduct the interview in the participant's language [289] or the researcher can work with an interpreter who conducts concurrent translation [284, 287, 295, 298, 302, 307, 319]. This method is preferable if there is not a bilingual researcher available with training in qualitative research, as it enables the researcher to direct the research and adjust data collection where necessary [284, 287, 304, 319]. The same

bilingual researcher or interpreter should be used for all interviews in each language in order to increase consistency, and consequently the trustworthiness of the data [288, 290, 294, 302, 308]. As for the translation of written materials, conceptual equivalence is recommended when translating data rather than attempting to achieve semantic equivalence. This is particularly pragmatic for semi-structured interviews where emphasising meaning and cultural context over word equivalence may enable more accuracy in translations [288, 290, 309-311, 322]. In the interview, data should also be interpreted in the third person in order to make the interpreter visible, to clearly make the use of translation explicit, and to make it evident that the translated narrative does not represent what participants said verbatim [284, 290, 301, 323].

After the interview, the researcher should discuss the interview with the interpreter [284, 285, 289, 290, 295, 302, 305, 308, 315-317]. This enables the interpreter to provide further insight into the meaning expressed in the interviews (e.g. supplementing translations with additional information or cultural knowledge), which improves the accuracy and trustworthiness of translations [284]. This also allows the researcher to gain the interpreter's reflections on the interview (including their perceptions of the interview or participant, or feedback on the interview methods or topic guide) [290, 304, 308, 315], and to discuss the interpreter's background [316, 324], both of which contribute to the process of reflexivity, increasing the validity of the data.

2.4.1.4 Management, analysis, and dissemination of data

Regardless of at what stage data are translated and transcribed, an independent individual with socio-linguistic and socio-cultural competence should review and validate the translated data.

Analysis, which can be conducted on original language or translated data, should involve individuals with socio-linguistic and socio-cultural knowledge of the participant group (e.g. translators or interpreters) [286, 290]. For example, the validity of the analysis can be improved by having multiple coders (particular a coder with socio-linguistic and socio-cultural competence like a translator or interpreter), or through discussion of the results with individuals who can provide cultural and linguistic knowledge. Content, narrative, and thematic analysis are appropriate for the analysis of translated data [282, 287, 289, 300, 302]. However, a phenomenological approach is not appropriate [286, 294, 295], unless the original language data are analysed.

In the dissemination of the study findings, all cross-language methods used throughout the research should be clearly and thoroughly described and justified, as the use of translation is a methodological issue affecting the validity of research [287, 288, 296, 322]. Challenges and limitations relating to the methods used should also be discussed [288, 296]. The use of cross-language methods should also ideally be stated in the abstract. In addition to the methods used, translators' and interpreters' involvement and roles in the research should be visible [290, 312, 315, 324]. This should partly been done through a process of active reflexivity, including reflecting on the translators' and interpreters' active and subjective involvement in the research, and their background (as well as the background of others involved in the research) [290, 303, 313, 316 282, 283, 286, 288, 290, 294-296, 300, 301, 306, 308, 309, 312, 314-316, 322, 324].

2.4.2 Conclusion

The methodological guidelines for conducting cross-language qualitative research identified through a synthesis of recommendations identified in the papers included in this review can be used to inform future cross-language qualitative research and to evaluate existing research. However, further insight into methods that can improve the validity of cross-language qualitative research is needed.

While the review identified recommendations for conducting cross-language qualitative research in the literature, it also revealed that there are a limited number of papers which rigorously identify methodological recommendations for cross-language qualitative research. Only one systematic review was identified, which discussed how the interpreter's role was described and how trustworthiness was determined in cross-cultural interview studies [290]. However, this paper did not aim to review methodological literature or papers evaluating the impact of cross-language research methods on validity, so consequently only provided insight into the methods used in existing research. Another paper did review the methodological literature relating to cross-language research, and identified criteria for evaluating studies based on the recommendations from the literature. However, this review was not systematic [282].

Additionally, while the papers included in this review discussed recommended methods for the use of translation and interpretation in research, there was a lack of research evaluating the impact of such methods on the validity of cross-language research.

Among the papers identified in this review, only four tested the impact of cross-language qualitative research methods on the study findings or validity [294, 295, 298, 308]. This is an important gap in the literature on cross-language qualitative research methods.

Further systematic reviews should be conducted to identify rigorous cross-language qualitative research methods, which can inform the development of guidelines for conducting cross-language qualitative research and criteria for rating quality in such research. Recommended methods should be tested in order to evaluate their impact on validity. Where there is evidence that a method can improve validity, it can be utilised to improve the accuracy and trustworthiness of future cross-language research, and the quality of existing research can be evaluated based on this evidence.

The research conducted in this PhD was guided by the recommendations identified in this review, and rigorous cross-language methods were utilised wherever possible given available resources (financial resources, availability of translators or interpreters, etc). In particular, recommendations that were in line with the other qualitative methods utilised in this research (e.g. for achieving quality and rigour, and sensitive research and postcolonial feminist research methods[325-333]) were prioritised. The guidelines relevant to the methods used in this research are described in Table 3.

Table 3 Cross-language methods used in qualitative study

Background of translators and interpreters	*Development and translation of written materials*	*Data Collection*	*Management, analysis, and dissemination of data*
• **Interpreter or translator should have socio-cultural and socio-linguistic competence.** • **Use professional credentialed translators for translating and interpreting.** • **Background of interpreter should be determined by participant's preferences as well as aims of research**.	• **Translation of written materials should be guided by participants' preferences and their literacy.** •**Translate meaning (conceptual equivalence).** • **Research materials should be developed in collaboration with individuals with socio-linguistic and socio-cultural knowledge of participant group.** • **Use the same translator for each language included.** •**Pilot topic guide and research materials.**	<u>Prior to the interview</u> • **Identify participants' language (and dialect) of preference for interviews;** • **Discuss the research with the interpreter prior to interviewing (including purpose of the interview, interpreting methods, interpreter's role, interview guide, confidentiality, needed training).** <u>During the interview</u> •**If translation in interview is needed, either use bilingual researcher or concurrent translation** (the latter is preferable where interpreter does not have background in qualitative research)**.** • **Use the same interpreter for all interviews in each language.** •**Translate meaning (conceptual equivalence).** • **Interpretation in third person to make interpreter visible.**	<u>Analysis</u> • **Analysis can be conducted on original language data or translated data. Validity increased by using multiple coders (particularly individuals with socio-linguistic and socio-cultural competence) or discussing analysis with individuals who can provide cultural and linguistic knowledge of the participant group.** • **Content, narrative, or thematic analysis appropriate for analysis of translated data; phenomenological approach not appropriate.** <u>Dissemination</u> • **Explicitly describe all cross-language methodologies used and justify choice of methods;** should state use of cross-language methods in abstract and methods sections of papers. • **Discuss methodological issues and limitations relating to use of cross-language methods.**

		<u>After the interview</u> • **Discuss the interview with the interpreter afterwards (interpreter can supplement translations, reflect on the research, and interpreter's background can be discussed).**	• **Make interpreters and translators visible/role of interpreters explicit in the research (**e.g. describe involvement of translators/interpreters, state worked 'with' interpreters)**.** • **Engage in active reflexivity (e.g. discuss background and impact of all involved in research).**

Chapter 3: The relationship between migration and psychological symptoms for women in South East London

3.1 Introduction

The previous chapters demonstrate the lack of consensus in the literature regarding whether migrant women are at increased risk of common mental disorders (including anxiety and depression), or Post Traumatic Stress Disorder (PTSD) compared to non-migrant women. As discussed in chapter 1, some research has found high rates of disorders within migrant populations [15-18, 27, 46-48], whereas other studies have found that some migrant populations experience lower morbidity compared to native populations in host countries or in their countries of origin [36-38]. Many studies on migration and mental health have failed to examine gender differences, or have adjusted for gender in multivariate models without stratifying by gender, even though the prevalence of mental disorders and risk factors are likely to be different for men and women.

Women typically experience higher rates of common mental disorders than men across populations [1-6, 334], and some studies have reported that migrant women experience a higher prevalence of depression, anxiety, and PTSD than male migrants [24]. Gender differences also exist in experiences of stressful life events, which are associated with common mental disorders and PTSD and may contribute to the disparity in the prevalence of common mental disorders between women and men [243, 244, 334-340]. For example, women report increased exposure to sexual violence and interpersonal events than men [10, 11]. Migrant women experience an additionally increased risk of stressful life events due to the conditions surrounding flight, relocation, and settlement in a new country of origin, and some migrant women experience very high rates of physical and sexual violence [71, 158], putting them at increased risk of experiencing common mental disorders or PTSD [157, 240-242].

Research has been conducted on specific groups of migrant women (e.g. asylum seekers, refugees, and trafficked women) who may be at increased risk of exposure to stressful life events and poor mental health outcomes compared to other migrant groups or native populations [158]. There is also some research exploring exposure to specific events, for example domestic violence [157, 167, 169, 171, 172, 247, 341-344]. However, there are

few studies that have examined differences in the risk of experiencing stressful life events or psychological symptoms between migrant women and non-migrant women.

3.1.1 Objectives

The specific objectives of this study are to:

Investigate whether among women living in South East London, first generation migrant women are at increased risk of experiencing high levels of psychological symptoms compared to women born in the UK using data from a cross-sectional survey (the SELCoH Study).

3.1.2 Hypothesis

First generation migrant women will be significantly more likely to experience high levels of psychological symptoms than women born in the UK, controlling for confounders, including stressful life events.

This will be tested using data from a cross-sectional survey (the South East London Community Health Study).

3.2 The SELCoH study

The quantitative analyses in this dissertation are secondary analyses which use data from a community survey, the South East London Community Health Study (SELCoH study) (which was funded by the National Institute for Health Research (NIHR) Mental Health Biomedical Research Centre at South London and Maudsley NHS Foundation Trust and King's College London and a joint infrastructure grant from Guy's and St Thomas' Charity and the Maudsley Charity')[345]. The study was carried out from 2008 to 2010, and is a cross-sectional survey of residents of private households in the South East London boroughs of Lambeth and Southwark. This study aimed to collect data on socio-demographic factors, socio-economic status, social resources, stressful life events, psychosocial indicators, and mental and physical health from a representative sample of the population in South East London [345].

The population in South East London is ethnically diverse. In Lambeth and Southwark, the two boroughs that make up the study catchment area, approximately 37% of the

population identifies as non-white. In Southwark, 8% of the population identifies as Caribbean, 16.1% as African, and 4.1% as Asian or Asian British. In Lambeth, 12.1% of the population identifies as Caribbean, 11.6% as African, and 4.6% as Asian or Asian British [175].

There is also a large migrant population in these boroughs. Of the 1,565,856 migrants born outside the UK living in London, 83,290 live in Lambeth, and 74,340 live in Southwark, comprising 31% and 30% respectively of the population for each borough [175]. The number of asylum seekers or refugees living in the study catchment area is estimated to be between 9,400-11,000 for Lambeth and 9,200-10,700 for Southwark [346].

The catchment area for the SELCoH study thus provided an opportunity to obtain data on a diverse population of women in London in order to explore the effect of migration and exposure to stressful life events on mental health.

3.2.1 SELCoH study inclusion and exclusion criteria

Inclusion criteria: Individuals aged 16 or over living in private residences which are their main residence in the boroughs of Lambeth or Southwark.

Exclusion criteria: Incorrect, non-private, shared, or vacant addresses, and individuals deemed unable to participate because they did not have capacity to consent or presented a possible risk to the researcher.

3.2.2 SELCoH study procedures

Households were identified through random sampling using the Small User Residential Postcode Address File, a database of private residences in the UK produced by the Royal Mail. Recruitment was conducted through letters sent to households, and household visits. Addresses were visited a maximum of four times (on different days and different times of day). (See [345] for further details of SELCoH study recruitment methodology).

Participants completed computer assisted survey questions with a member of the SELCoH Study research team, and were able to select their responses to questions on a laptop screen if preferred. For individuals who requested to complete the survey in a language other than English, a trained interpreter was present at the interview and

worked with the researcher providing simultaneous translation. Prior to beginning the interview, the interpreter went through the information sheet and consent form with the participant, providing the study information in the participant's language.

3.2.3 SELCoH Study sample

Contact was made with a total of 2,070 private households, within which 2,359 individuals were eligible to participate. At least one individual was interviewed from 1,075 households, resulting in a household participation rate of 51.9%. A total of 1,698 participants were interviewed, resulting in a participation rate within households of 71.9%. Sample sizes in each of the boroughs were comparable. The sample was similar to the 2011 UK Census with regards to socio-demographic and socio-economic indicators for the catchment area under study (including for individuals born outside the UK) [347].

959 (56.5%) of the participants were women, 944 (98.4%) of whom indicated their migrant status and were included in the analysis studying this chapter. 240 (25.0%) women in the SELCoH study reported they did not speak English as a first language, and translation was needed for 25 (2.6%) of the interviews with women [345].

3.3 Methods of study of psychological symptoms in migrant women and women born in the UK

3.3.1 Study population

The study compares first generation migrant women and women born in the UK who participated in the SELCoH Study.

3.3.1.1 Inclusion and exclusion criteria

Women interviewed in the SELCoH Study who indicated their migrant status were included in the analysis. Male participants in the SELCoH Study were excluded.

Cases: first generation migrant women (female participants in the SELCoH study who indicated their country of birth is outside the UK).

Controls: women born in the UK (female participants in the SELCoH study who indicated their country of birth is within the UK).

3.3.2 Covariates

The variables used in this study utilise the survey data collected in the SELCoH study (for relevant sections of the survey questionnaire see Appendix 3, page 374), and were selected based on relationships between risk factors and psychological symptoms identified in the literature on migration and mental health (see chapter 1, page 11 and section 3.1, page 91).

3.3.2.1 Individual characteristics

3.3.2.1.1 Socio-demographic characteristics

Migrant status: This binary variable was developed using participants' reported countries of birth. All women born in the UK are categorised as non-migrants. All women born outside of the UK are categorised as first generation migrants.

Age: Age was analysed as a continuous variable. Self-reported age, provided on the SELCoH Study contact details form, and reported age on last birthday in the SELCoH Study survey differed for 40 observations. For the 40 differing observations, the age on the last birthday was calculated using the date of the interview and the reported date of birth.

Ethnic category: Included: White, Black Caribbean, Black African, and Asian and Other. Individuals whose reported ethnicity was Black (Other Black Groups), Indian, Pakistani, Bangladeshi, Chinese, or 'none of these' (who were subsequently able to specify their ethnicity) in the SELCoH questionnaire (see Appendix 3, page 374), were categorised as 'Asian and Other'.

Relationship status: Categorised as 'single' (single and never married); 'married/cohabiting' (single and living with your partner or married and living with your husband/wife); and 'divorced/separated or widowed' (married and separated from your husband/wife, divorced, widowed).

Number of children: This continuous variable indicates the total number of children each participant reported having, including those living with and not living with the participant.

3.3.2.1.2 Socio-economic status

Household monthly gross income category: Participants were asked to select which category represented their household's monthly gross income, defined as income from all sources, prior to deductions for income tax and national insurance, and including social security benefits and private/occupational pension but excluding housing benefit and council tax benefit. The categories included: £0 to £420 per month; £421 to £928 per month; £929 to £1,592 per month; £1,593 to £2,416 per month; and £2,417 per month or more.

Employment status: The reported work status of participants in the SELCoH study survey were categorised as follows: 'In paid employment' (full time work, part time work, casual work, or student (working part time (≤ 35 hours per week) or full time (> 35 hours per week)); 'unemployed'; 'economically inactive' (temporary sick, permanent sick/disabled, retired, or student (not working)); and 'at home looking after children' (looking after the home with children < 16 or looking after the home with children ≥ 16).

The 2001 Census recognises individuals who are in paid employment or unemployed as 'economically active', defined as currently working, looking for work, or available to start work within two weeks. Individuals who are at home looking after children are recognised as 'economically inactive' [175]. Individuals who identified as being unemployed were categorised separately in this analysis as unemployment is associated with psychological symptoms [348, 349]. Individuals at home looking after children were also categorised separately as this is an important labour role for women, though it is typically considered to be outside the productive sphere.

Education level: This included: 'no qualification'; 'GCSE or A-level equivalent'; and 'degree level or above'.

3.3.2.2 Physical Health

Long standing physical conditions: Participants were asked if they have any long-standing illness, disability or infirmity. This variable utilises reported physical conditions including: asthma, chronic bronchitis, other chest trouble, diabetes, stomach or other digestive disorder, liver trouble, rheumatic disorder or arthritis, heart trouble,

high blood pressure, stroke, migraine, back trouble, epilepsy/fits, gynaecological problem, irritable bowel syndrome, cancer, or 'other' self-reported physical conditions. The following self-reported long standing conditions reflecting mental illness or related symptoms were not included as physical problems: depression or other nervous illness, eating disorders, obsessive compulsive disorders, paranoid schizophrenia, autism, PTSD, possible somatoform disorders (e.g. fatigue, chronic fatigue syndrome, or myalgic encephalomyelitis, chronic pain), or memory problems.

3.3.2.3 Social Resources

Social support: Participants were asked if they could get help or assistance if they needed it in four specific situations pertaining to instrumental support ('someone to lend you money to pay bills or help you get along' or 'someone to help you deal with an emergency (minor or health emergency)') and emotional support ('someone to talk to about something that was bothering you or when you felt lonely and wanted some company' or 'someone to make you feel good, loved, or cared for'). Individuals were categorised as having low social support if they could get help or assistance in 0-2 situations, and high social support if they could get help or assistance in 3-4 situations.

Social network size: Participants were asked to identify how many of the following types of individuals they come into contact with (face to face or by phone) in a typical week (range 0-10): a brother or sister, in-laws, other relatives, close friends, neighbours, co-workers, a boss or supervisor, other acquaintances, helping professionals, or a member of the same group or club.

3.3.2.4 Stressful life events

Stressful life events were categorised according to whether or not they were potentially traumatic (threatening to one's life or physical integrity), and whether they occurred in childhood or in one's lifetime. Events identified to have occurred in childhood (before the age of 16) were examined separately from lifetime events because childhood stressful life events have been shown to have a distinct impact on mental health, and in some cases to increase vulnerability to poor mental health outcomes like PTSD [350]. This was also line with research suggesting that the effect of childhood stressful life events on adulthood mental health must be considered in the context of lifetime stressful life events [351].

Childhood stressful life events:

Potentially traumatic childhood stressful life events included: a major accident or illness requiring a week or more in hospital; being hit so hard it left bruises or marks; or being sexually abused.

Other childhood stressful life events included: spending time in an institution; being taken into Local Authority Care; parental divorce; death of parents; or separation from either parent. In the responses to being taken into Local Authority Care in the survey, 130 migrant women selected 'Does Not Apply (DNA), foreign national' as this was not applicable given the systems in their countries of origin. These responses were coded as 'not experienced' in the analysis, but it is important to note these women's circumstances may not be comparable to women born in the UK who were not taken into local authority care.

Lifetime stressful life events:

Potentially traumatic lifetime stressful life events included: a serious accident; being in combat in war, living near a war zone, or being present during a political uprising; witnessing violence; being the victim of a serious crime; being injured with a weapon; or being hit, bit, slapped, kicked, or forced to have sex against one's wishes.

Other lifetime stressful life events included: the end of a relationship following cohabitation; the death of a loved one; a period sleeping in a park or temporary residence because no money was available for rent; the illness or serious accident of a child; or having a child with special needs.

3.3.2.5 Outcome measures

High levels of psychological symptoms: High levels of symptoms of common mental disorders or Post Traumatic Stress Disorder (PTSD) as defined by the cut-points described below. Symptoms of both common mental disorders and PTSD were included given that stressful life events were likely to be important risk factors for migrant women.

An individual was categorised as experiencing high levels of symptoms of common mental disorders (e.g. anxiety or depression) by scoring 12 or higher on the Clinical

Interview Schedule – Revised Version (CIS-R) [352], a structured interview schedule measuring the presence of any neurotic symptoms in the past month and their severity in the past week. The cut off score of 12 is the threshold determined by Lewis et al (1992) and indicates a significant level of symptoms (scores of more than 17 indicate a level of symptoms indicating possible need for treatment). This indicator is widely used, and is a measure that enables findings to be compared with results in other studies [7, 240, 345, 353].

The PTSD screen was administered to individuals who reported experiencing a potentially traumatic stressful life event. An individual was categorised as experiencing high levels of PTSD symptoms if they scored three or four (range 0-4) on the PTSD screen. This four item screening tool measures symptoms experienced in the past month corresponding to the Diagnostic and Statistical Manual of Mental Disorders (IV) (DSM-IV) classification for PTSD [182], and has been utilised in previous research [354].

Three categories of disorder were also generated as there are 12 primary diagnoses identified from CIS-R scores according to ICD-10 disorders [355]. Categories included: 1) no disorder; 2) neurotic, stress-related, and somatoform disorders (including non-specified neurotic disorder[1], generalised anxiety disorder mild, generalised anxiety disorder, obsessive compulsive disorder, mixed anxiety and depressive disorder, specific (isolated) phobia, social phobia, agoraphobia, and panic disorder); and 3) depressive disorders (including mild depressive episode, moderate depressive episode, and severe depressive episode).

3.3.3 Statistical analysis

Data analysis was conducted using Stata statistical software (Release 10) [356].

3.3.3.1 Descriptive analysis

I initially carried out a descriptive analysis examining differences in means and proportions in the distribution of individual characteristics and experiences of stressful life events for migrant women and women born in the UK in the sample (command *svy:*

[1] A non-specified neurotic disorder included any score of 12 or higher on the CIS-R that did not meet the criteria for any other primary diagnosis.

tab x y, row ci). The *svy* command accounts for the survey design and weighting (see section 3.3.3.7, page 103 for a description of weighting of survey data). Logistic regression (command *xi: svy: logistic y i.x*) was used to test for differences between migrant women and women born in the UK, and crude odds ratios with 95% confidence intervals were calculated.

3.3.3.2 Univariate analysis

In the univariate analysis I examined the association of migrant status, individual characteristics, and stressful life events with high levels of psychological symptoms. Logistic regression was used to identify unadjusted odds ratios with 95% confidence intervals and p-values.

As the univariate analysis for stressful life events included a large number of statistical tests, the Holm-Bonferroni (or sequentially rejective Bonferroni) method was used to correct for multiple testing [357, 358]. This method is used instead of the Bonferroni test as it has been shown to be more likely to reject false hypotheses [358].

3.3.3.3 Multivariate analysis

In the multivariate analysis I used logistic regression to examine the relationship between migrant status and psychological symptoms, adjusting for age (a common confounder for psychological symptoms) and each covariate individually, then adjusting for all covariates simultaneously. Both childhood and lifetime stressful life events were included in the fully adjusted model.

3.3.3.4 Power calculation

This study had 553 women born in the UK and 391 migrant women. I predicted a prevalence of high levels of psychological symptoms of 25% in women born in the UK based on previous population studies in England [7, 345]. I estimated that with this sample size, I would be able to detect a prevalence of high levels of psychological symptoms in 35% of migrants with a power of 90% at the 5% significance level and a prevalence of 34% with a power of 80% at the 5% significance level.

3.3.3.5 Testing for normal distribution

Continuous variables were checked for normal distribution prior to analysis using a skewness-kurtosis test for normality (command *sktest x*). Testing for normal distribution was important as analyses and confidence intervals assume normal distribution of the variables, and non-parametric data can skew the results. If variables were identified to be non-parametric, the appropriate transformations were determined for the variables. This was informed by using the command *qladder*.

A sensitivity analysis was then undertaken to determine if transforming a variable qualitatively changed the association of the variable with psychological symptoms (e.g. whether or not there was an association). Following the multivariate analysis a sensitivity analysis was also conducted using the fully adjusted model. Due to the limitations of transforming data [359], if the conclusions of these tests were not qualitatively different, the original variable was retained for analysis and no transformation was utilised. Transforming non-parametric data is not necessary when the results do not differ qualitatively (and conclusions remain unchanged) when the data are transformed [360]. Additionally, parametric tests are valid for use with non-parametric data for large sample sizes (e.g. >100), as statistical tests have increased power and more precise estimates can be made (central limit theorem) [361].

3.3.3.6 Missing values

Missing values were examined to consider how the data may be biased, and to avoid type II error [362]. Missing data can fall into three categories:

'Missing completely at random' refers to data where the likelihood that an observation is missing is unrelated to the value of the variable it is missing for, as well as the value of observed data for other variables in the dataset. This type of missing data, while reducing power, does not bias the results due to its randomness, and can be addressed with listwise deletion. In the SELCoH Study dataset, data could be considered missing completely at random if it was missing due to being non-applicable or a logical skip, equipment, interview, or software error, or the variable not having been constructed at the point of surveying the participant. For missing data due to refusal to answer, the participant not knowing the answer, or true missing (where it is not known why the data were not recorded), the data could not be assumed to be missing completely at random.

Data 'missing at random' are not independent of the value of the observed data for other variables in the dataset, but are still independent of the value of the missing data (once these variables are accounted for). For example, if a migrant is less likely to respond to a question about experiences of abuse than a non-migrant, then missingness is dependent on migrant status. This has the potential to bias the findings. For example if migrants are more likely to experience abuse than non-migrants, then data missing for migrants makes the exposure to abuse within the sample appear lower. However, if migrant status is controlled for, and among migrants the probability of omitting a response is not dependent on the value of the missing data (if they have experienced abuse or not), then this missing data are 'missing at random'. This type of missing data can be accounted for in the analysis to reduce bias, and methods such as listwise deletion may be used.

Data 'missing not at random' occur when missingness is dependent on the value of the missing data, for example if individuals who have been abused are less likely to report abuse than individuals who have not experienced abuse. This has the potential to bias the results, as the estimate of the prevalence of abuse for the population may be deflated. Data determined to be 'missing not at random' is non-ignorable, which means that methods like listwise deletion do not reduce the bias produced by the missing data. However, it is not always feasible to ascertain from a dataset if this is the case [362, 363].

3.3.3.6.1 Missing values analysis

A missing values analysis was conducted to investigate if missing data were dependent on migrant status, the exposure of interest (potentially 'missing at random'), and where this was the case, if the missing data had the potential to bias the analyses. It should be recognised that it cannot be determined from the dataset if data are 'missing not at random', so the assumption was made that the reason for missingness was not dependent on the value of the missing data.

In Stata, the *mvpatterns* command was utilised to examine patterns of missing values for individual characteristics, stressful life events, and psychological symptoms. Binary variables for missing values in the variables were created, coded 0 for not missing, and 1 for missing. This was done using the command *egen* $variable_{miss}$ = *rmiss(*$variable_{original}$*)*. Analyses were then carried out to examine the distribution of

missing data across the above variables for migrant women and women born in the UK, and to determine whether missingness was dependent on (associated with) migrant status. Fisher's exact test was used for all univariate analyses where any $n \leq 5$. χ^2 tests were used for all other comparisons.

Where missingness was not found to be dependent on migrant status, listwise deletion was used. For variables where missingness was associated with migrant status significant at the $p<0.05$ level, data were suggested to be 'missing at random'. For such data, missingness can be addressed by including the variable predictive of missingness as a covariate in the multivariate analysis (which migrant status was, in line with the study aims), and listwise deletion was also used [362].

Sensitivity analysis: The analyses make the assumption that data are not 'missing not at random', so a sensitivity analysis was undertaken to examine the potential for missingness to bias the study conclusions (e.g. in the case that data were missing not at random) [362]. The association of each variable (for which missing data were dependent on migrant status) and migrant status was tested with missing values reassigned as a) the maximum value, and b) the minimum value of each variable.

3.3.3.7 Weighting of survey data

Data from the SELCoH Study were weighted for non-response bias (within households). Inverse probability weights were calculated based on predicted response probabilities of completing the survey for eligible residents. Analysis also accounted for clustering by household, which occurred due to study design (see [345] for further information regarding weighting). Analyses account for the survey design and weighting in order to provide population estimates; the following commands were used: *svy*; *svyset phouse [pweight=pw1]*. Sample sizes, medians, quartiles, and ranges are unweighted, representing the study sample.

3.4 Results

3.4.1 Sample size

A total of 944 women were included in the SELCoH study, comprised of 391 (40.3%) first generation migrant women and 553 (59.7%) women born in the UK.

3.4.2 Normality

The continuous variables (age, number of children, and social network size) were not normally distributed. Transformation did not qualitatively change the association of the variables with psychological symptoms, so the non-transformed variables were retained for analyses.

3.4.3 Missing values

The associations of missing values for individual characteristics, stressful life events, and psychological symptoms with migrant status are presented in Table 4 (for the distribution of missing values for study variables, see Appendix 4, page 390). Missingness was not found to be dependent on migrant status for any variables. In the analysis, listwise deletion was used and only complete cases were analysed in each test.

Table 4 Missing values for covariates by migrant status†

Variable	Born in the UK n (%)	Migrant n (%)	$X^2(df)$	*p-value*
Socio-demographic characteristics				
Age	0 (0.0)	0 (0.0)		---
Ethnic category	1 (0.2)	0 (0.0)		*1.00*
Relationship status	0 (0.0)	0 (0.0)		---
Number of children	0 (0.0)	0 (0.0)		---
Socio-economic status				
Household monthly gross income category	82 (14.8)	55 (14.1)	$X^2(1) = 0.1$	*0.74*
Employment status	1 (0.2)	3 (0.8)		*0.31*
Education Level	6 (1.1)	7 (1.8)	$X^2(1) = 0.8$	*0.36*
Physical health				
Long standing physical condition	3 (0.5)	5 (1.3)		*0.29*
Social resources				
Social support	6 (1.1)	7 (1.8)	$X^2(1) = 0.8$	*0.36*
Social network size	1 (0.2)	0 (0.0)		*0.07*
Stressful life events				
Potentially traumatic childhood stressful life events	8 (1.5)	6 (1.5)	$X^2(1) = 0.0$	*0.91*
Other childhood stressful live events	5 (0.9)	5 (1.3)	$X^2(1) = 0.3$	*0.58* *0.33*
Potentially traumatic lifetime stressful life events	4 (0.7)	6 (1.5)		
Other lifetime stressful life events	8 (1.5)	10 (2.6)	$X^2(1) = 1.5$	*0.22*
Mental health measure				
Psychological symptoms††	4 (0.7)	2 (0.5)		*1.00*

† Fisher's exact test was used for all univariate analyses where any n≤5. χ^2 tests were used for all other comparisons.
†† This included either meeting the cut off score of 12 in the CIS-R or screening positive on the PTSD screen.
* p<.05 ** p<.01 *** p<.001

3.4.4 Descriptive results: Characteristics and exposure to stressful life events for migrant women and women born in the UK

3.4.4.1 Characteristics of migrant women and women born in the UK

The characteristics of the migrant women and women born in the UK are presented in Table 5. For unweighted distributions and missing values, see Appendix 4, Table 33, page 390. Migrant women were significantly more likely to be at home looking after children, and to have more children. Women born in the UK were significantly more likely to be white, earn a higher income (e.g. a household weekly gross income of £2,417 or more per month), be single, and have a high level of social support.

There was no difference between migrant women and women born in the UK in levels of emotional support (someone to talk to or give you company (OR: 1.0 [95% CI: 0.6 – 1.7]), or make you feel good, loved, or cared for (OR: 0.8 [95% CI: 0.4 – 1.5])). Women born in the UK were significantly more likely to have instrumental support (someone to lend you money (OR: 0.5 [95% CI: 0.3 – 0.7]) or help you deal with an emergency (OR: 0.5 [95% CI: 0.3 – 0.9]) (Not shown in Table 5).

Table 5 Individual characteristics of migrant women and women born in the UK†

Variable	Born in the UK		Migrant		Unadjusted OR [95% CI]	*p-value*
	n	% [95% CI]	n	% [95% CI]		
Socio-demographic characteristics						
Age , years (n=944) Mean (S.E.) [95%CI] Median (25th and 75th percentiles) (Range)	553	 44.1 (0.9) [42.2 – 46.0] 37 (25, 51) (16-89)	391	 42.5 (0.9) [40.7 – 44.4] 36 (29, 50) (16-89)	1.0 [1.0 – 1.0]	*0.24*
Ethnic Category (n=943)						
White	421	79.3 [75.3 – 82.8]	154	38.5 [33.5 – 43.9]	1.0	
Black Caribbean	44	6.8 [4.9 – 9.6]	46	13.2 [9.8 – 17.6]	4.0 [2.4 – 6.5]	*<0.001****
Black African	29	4.6 [3.1 – 6.9]	104	26.1 [21.6 – 31.2]	11.6 [7.2 – 18.6]	*<0.001****
Asian and Other	58	9.2 [6.9 – 12.2]	87	22.1 [18.0 – 26.8]	4.9 [3.3 – 7.5]	*<0.001****
Relationship Status (n=944)						
Single	242	39.3 [35.2 – 43.5]	118	27.4 [23.1 – 32.3]	1.0	
Married/cohabiting	221	40.3 [36.2 – 44.6]	191	47.9 [42.8 – 53.1]	1.7 [1.3 – 2.3]	*0.001***
Divorced/separated/widowed	90	20.4 [16.9 – 24.5]	82	24.3 [20.2 – 29.6]	1.7 [1.2 – 2.6]	*0.006***
Number of Children (n=944) Mean (S.E.) [95%CI] Median (25th and 75th percentiles) (Range)	553	 1.3 (0.1) [1.2 – 1.5] 1 (0, 2) (0-11)	391	 2.0 (0.1) [1.7 – 2.2] 1 (0,3) (0-14)	1.2 [1.1 – 1.3]	*<0.001****
Socio-economic status						
Household Monthly Gross Income Category (n=807)						
£0 - £420	45	10.1 [7.5 – 13.5]	41	12.9 [9.5 – 17.4]	1.0	
£421 - £928	66	16.5 [13.1 – 20.6]	64	19.7 [15.6 – 24.5]	0.9 [0.5 – 1.6]	*0.81*
£929 - £1,592	58	12.5 [9.6 – 16.1]	65	20.7 [16.4 – 25.8]	1.3 [0.7 – 2.3]	*0.38*
£1,593 - £2,416	52	10.7 [8.1 – 14.1]	46	13.3 [9.9 – 17.5]	1.0 [0.5 – 1.8]	*0.92*
£2,417 or more	250	50.2 [45.4 – 55.1]	120	33.5 [28.4 – 38.9]	0.5 [0.3 – 0.9]	*0.01**
Employment Status (n=940)						
In paid employment	311	53.1 [48.7 – 57.5]	205	49.8 [44.6 – 55.1]	1.0	
Unemployed	49	8.2 [6.1 – 10.8]	41	10.0 [7.3 – 13.6]	1.3 [0.8 – 2.1]	*0.27*
Economically inactive	159	33.5 [29.3 – 38.0]	94	28.9 [24.2 – 34.1]	0.9 [0.7 – 1.3]	*0.61*
At home looking after children	33	5.2 [3.7 – 7.2]	48	11.2 [8.5 – 14.7]	2.3 [1.4 – 3.7]	*0.001***

Education level (n=931)						
No qualification	72	16.8 [13.4 – 20.8]	52	17.2 [13.2 – 22.0]	1.0	
GCSE or A-level or equivalent	245	42.8 [38.5 – 47.3]	179	46.4 [41.2 – 51.6]	1.1 [0.7 – 1.6]	*0.79*
Degree level or above	230	40.4 [36.1 – 44.8]	153	36.5 [31.7 – 41.6]	0.9 [0.6 – 1.4]	*0.57*
Physical health						
Long standing condition (n=936)						
No	323	54.3 [50.0 – 58.6]	241	57.7 [52.3 – 62.8]	1.0	
Yes	227	45.7 [41.5 – 50.0]	145	42.4 [37.2 – 47.7]	0.9 [0.7 – 1.2]	*0.33*
Social resources						
Social support (n=931)						
Low support	29	6.1 [4.2 – 8.8]	40	10.4 [7.7 – 14.0]	1.0	
High support	518	93.9 [91.2 – 95.8]	344	89.6 [86.0 – 92.3]	0.6 [0.3 – 0.9]	*0.02**
Social network size (n=939)	552		387		1.0 [0.9 – 1.0]	*0.18*
Mean (S.E.) [95%CI]		5.0 (0.1) [4.9 – 5.2]		4.9 (0.1) [4.7 – 5.1]		
Median (25th and 75th percentiles)		5 (4, 6.5)		(5 (3, 6)		
(Range)		(0-10)		(0-10)		

† Data have been weighted to correct for non-response bias, and for clustering in the household survey. Analysis accounts for the survey design and the weighting. Sample sizes, medians, quartiles, and ranges are unweighted.

* p<.05 ** p<.01 *** p<.001

3.4.4.2 Experiences of stressful life events among migrant women and women born in the UK

3.4.4.2.1 Childhood stressful life events

When examining discrete childhood events, a greater percentage of women born in the UK than migrant women in the sample were found to have spent time in an institution or to have been taken into local authority care, and migrants were significantly more likely to have experienced physical abuse. However, when examining types of childhood events, no significant difference was found between migrant women and women born in the UK in the experience of potentially traumatic childhood stressful life events or other childhood stressful life events (see Table 6). For unweighted distributions and missing values, see Appendix 4, Table 34, page 393.

3.4.4.2.2 Lifetime Stressful Life Events

When examining discrete individual lifetime events, women born in the UK were significantly more likely to report being the victim of a serious crime, or physical or sexual abuse, than migrant women. However, no significant differences were found between migrant women and women born in the UK when examining exposure to grouped types of life events (potentially traumatic stressful life events [a serious accident; being in combat in war, living near a war zone, or being present during a political uprising; witnessing violence; being the victim of a serious crime; being injured with a weapon; or being hit, bit, slapped, kicked, or forced to have sex against one's wishes] or other lifetime stressful life events [the end of a relationship following cohabitation; the death of a loved one; a period sleeping in a park or temporary residence because no money was available for rent; the illness or serious accident of a child; or having a child with special needs]) (see Table 7, page 112). For unweighted distributions and missing values, see Appendix 4, Table 35, page 395.

Table 6 Experiences of childhood stressful life events among migrant women and women born in the UK†

Variable	Born in the UK		Migrant		Unadjusted OR [95% CI]	*p-value*
	n	%, [95% CI]	n	%, [95% CI]		
Potentially traumatic childhood stressful life events (n=930)						
Not experienced	355	64.1 [59.8 – 68.1]	*240*	62.0 [56.9 – 66.9]	1.0	
Experienced	190	35.9 [31.9 – 40.2]	*145*	38.0 [33.1 – 43.1]	1.1 [0.8 – 1.4]	*0.54*
Other childhood stressful life events (n=934)						
Not experienced	314	56.9 [52.5 – 61.2]	*211*	54.5 [49.2 – 59.6]	1.0	
Experienced	234	43.1 [38.8 – 47.5]	*175*	45.5 [40.4 – 50.8]	1.1 [0.8 – 1.5]	*0.48*
Spend time in an institution (n=944)						*0.02**
Not experienced	527	94.1 [92.6 – 96.6]	382	97.9 [96.0 – 98.9]	1.0	
Experienced	26	5.0 [3.4 – 7.4]	9	2.1 [1.1 – 4.0]	0.4 [0.2 – 0.9]	
Taken into Local Authority Care (n=944)						*0.001***
Not experienced	526	95.0 [92.7 – 96.6]	386	98.8 [97.2 – 99.5]	1.0	
Experienced	27	5.0 [3.4 – 7.4]	5	1.2 [0.5 – 2.8]	0.3 [0.1 – 0.9]	
Major accident or illness (n=938)						*0.17*
Not experienced	429	75.9 [71.9 – 79.5]	309	79.9 [75.4 – 83.7]	1.0	
Experienced	122	24.1 [20.6 – 28.1]	78	20.1 [16.3 – 24.6]	0.8 [0.6 – 1.1]	
Parental divorce (n=937)						*0.54*
Not experienced	452	83.6 [80.2 – 86.5]	324	85.1 [81.2 – 88.3]	1.0	
Experienced	98	16.4 [13.5 – 19.8]	63	14.9 [11.7 – 18.8]	0.9 [0.6 – 1.3]	
Death of parents (n=934)						*0.29*
Not experienced	500	89.5 [86.2 – 92.1]	340	87.0 [83.0 – 90.2]	1.0	
Experienced	48	10.5 [7.9 – 13.8]	46	13.0 [9.8 – 17.0]	1.3 [0.8 – 2.0]	
Separation from parents (n=936)						*0.90*
Not experienced	345	62.5 [58.2 – 66.7]	242	62.9 [57.8 – 67.8]	1.0	
Experienced	205	37.5 [33.4 – 41.8]	144	37.1 [32.2 – 42.2]	1.0 [0.7 – 1.3]	
Physical abuse (n=936)						*0.005***
Not experienced	459	84.0 [80.5 – 87.0]	298	76.3 [71.1 – 80.4]	1.0	
Experienced	90	16.0 [13.0 – 19.5]	89	23.7 [19.6 – 28.4]	1.6 [1.2 – 2.3]	
Sexual abuse (n=932)						*0.30*

Not experienced	509	92.9 [90.3 – 94.8]	365	94.6 [91.7 – 96.6]	1.0	
Experienced	38	7.1 [5.2 – 9.7]	20	5.4 [3.5 – 8.3]	0.7 [0.4 – 1.3]	

† Data have been weighted to correct for non-response bias, and for clustering in the household survey. Analysis accounts for the survey design and the weighting. Sample sizes, medians, quartiles, and ranges are unweighted.

* p<.05 ** p<.01 *** p<.001

Table 7 Experiences of lifetime stressful life events among migrant women and women born in the UK†

Variable	Born in the UK		Migrant		Unadjusted OR [95% CI]	*p-value*
	n	%, [95% CI]	n	%, [95% CI]		
Potentially traumatic lifetime stressful life events (n=934)						*0.13*
Not experienced	164	28.6 [24.8 – 32.8]	*126*	33.5 [28.7 – 38.6]	1.0	
Experienced	385	71.4 [67.2 – 75.2]	*259*	66.5 [61.4 – 71.3]	0.8 [0.6 – 1.1]	
Other lifetime stressful life events (n=926)						*0.20*
Not experienced	151	25.0 [21.6 – 28.8]	88	21.4 [17.5 – 25.9]	1.0	
Experienced	394	75.0 [71.3 – 78.4]	293	78.6 [74.2 – 82.5]	1.2 [0.9 – 1.7]	
End of a relationship following cohabitation (n=938)						*0.11*
Not experienced	356	64.3 [59.9 – 68.4]	231	58.9 [53.6 – 63.9]	1.0	
Experienced	195	35.7 [31.6 – 40.1]	156	41.1 [36.1- 46.4]	1.3 [1.0 – 1.7]	
Death of a loved one (n=937)						*0.17*
Not experienced	259	43.0 [38.8 – 47.3]	158	38.4 [33.6 - 43.5]	1.0	
Experienced	292	57.0 [52.7 – 61.2]	228	61.6 [56.5 – 66.4]	1.2 [0.9 – 1.6]	
Witnessing violence (n=937)						*0.64*
Not experienced	350	65.1 [60.8 – 69.2]	253	66.6 [61.7 – 71.2]	1.0	
Experienced	201	34.9 [30.8 – 39.2]	133	33.4 [28.8 – 38.3]	0.9 [0.7 – 1.2]	
Serious accident (n=938)						*0.12*
Not experienced	460	83.2 [79.7 – 86.2]	305	78.9 [74.3 – 82.9]	1.0	
Experienced	91	16.8 [13.8 – 20.3]	82	21.1 [17.1 – 25.7]	1.3 [0.9 – 1.9]	
Exposure to conflict (n=938)						*0.22*
Not experienced	500	88.2 [84.6 – 91.1]	329	85.2 [81.2 – 88.5]	1.0	
Experienced	51	11.8 [8.9 – 15.4]	58	14.8 [11.5 – 18.8]	1.3 [0.9 – 2.0]	
Homelessness (n=938)						*0.30*
Not experienced	526	95.2 [92.9 – 96.8]	361	93.5 [90.5 – 95.6]	1.0	
Experienced	25	4.8 [3.3 – 7.1]	26	6.5 [4.4 – 9.5]	1.4 [0.8 – 2.5]	
Being the victim of a serious crime (n=938)						*0.001***
Not experienced	336	59.9 [55.5 – 64.2]	274	70.7 [65.8 – 75.2]	1.0	
Experienced	215	40.1 [35.9 – 44.5]	113	29.3 [24.9 – 34.2]	0.6 [0.5 – 0.8]	

Being injured with a weapon (n=938)						*p = 0.81*
Not experienced	513	93.0 [90.4 – 95.0]	360	92.6 [89.1 – 95.0]	1.0	
Experienced	38	7.0 [5.1 – 9.6]	27	7.4 [5.0 – 10.9]	1.1 [0.6 – 1.8]	
Physical or sexual abuse (n=938)						*0.03**
Not experienced	382	70.7 [66.6 – 74.5]	298	77.2 [72.6 – 81.2]	1.0	
Experienced	167	29.3 [25.5 – 33.4]	88	22.9 [18.8 – 27.4]	0.7 [0.5 – 1.0]	
Serious illness or accident of a child (n=929)						*0.25*
Not experienced	493	89.7 [86.7 – 92.1]	334	87.2 [83.4 – 90.3]	1.0	
Experienced	53	10.3 [7.9 – 13.3]	49	12.8 [9.7 – 16.6]	1.3 [0.8 – 2.0]	
Having a child with special needs (n=929)						*0.22*
Not experienced	511	93.4 [90.8 – 95.3]	351	91.1 [87.6 – 93.7]	1.0	
Experienced	35	6.6 [4.8 – 9.2]	32	8.9 [6.3 – 12.4]	1.4 [0.8 – 2.3]	

† Data have been weighted to correct for non-response bias, and for clustering in the household survey. Analysis accounts for the survey design and the weighting Sample sizes, medians, quartiles, and ranges are unweighted.

* p<.05 ** p<.01 **** p<.001

3.4.5 Univariate results: Association of covariates with psychological symptoms

3.4.5.1 High levels of psychological symptoms among migrant women and women born in the UK

There was no significant difference found in the proportion of migrant women and women born in the UK experiencing high levels of psychological symptoms. 28.9% [95% CI: 26.0 – 32.1] of all women were found to experience a high level of symptoms, and similar levels of both migrant women and women born in the UK met the criteria for high levels of psychological symptoms (see Table 8).

Similarly, there were no significant differences in CIS-R scores, the distribution of primary diagnoses, or presence of PTSD symptoms for migrant women and women born in the UK. 27.3% [95% CI: 24.4 – 30.4] of women in the sample had a significant level of symptoms for common mental disorders, scoring above 12 on the CIS-R, and 6.4% [95% CI: 5.0 – 8.2] met the criteria for PTSD symptoms (see Table 8). For unweighted distributions and missing values, see Appendix 4, Table 36, page 397.

Table 8 High levels of psychological symptoms among migrant women and women born in the UK†

Variable	Born in the UK		Migrant		Unadjusted OR [95% CI]	*p-value*
	n	%, [95% CI]	n	%, [95% CI]		
High levels of psychological symptoms††						*0.77*
No	385	71.4 [67.4 – 75.1]	278	70.5 [65.4 – 75.2]	1.0	
Yes	164	28.6 [24.9 – 32.6]	111	29.5 [24.8 – 34.6]	1.1 [0.8 – 1.4]	
CIS-R total score category†††						*0.92*
0-11	391	72.4 [68.4 – 76.1]	288	72.8 [67.8 – 77.3]	1.0	
12-17	71	12.2 [9.7 – 15.2]	47	12.7 [9.6 – 16.7]	1.0 [0.7 – 1.6]	
18+	88	15.4 [12.6 – 18.7]	56	14.5 [11.2 – 18.6]	0.9 [0.6 – 1.4]	
CIS-R primary diagnosis: common mental disorder diagnostic categories††††						*0.21*
No disorder	379	70.1 [66.1 – 73.9]	268	67.8 [62.7 – 72.5]	1.0	
Neurotic, stress-related, and somatoform disorders	88	15.3 [12.5 – 18.7]	76	19.7 [15.9 – 24.0]	1.3 [0.9 – 1.9]	
Depressive disorders	84	14.5 [11.8 – 17.8]	47	12.6 [9.4 – 16.5]	0.9 [0.6 – 1.3]	
Post Traumatic Stress Disorder (PTSD) screen†††††						*0.52*
No	516	93.9 [91.6 – 95.6]	357	92.8 [89.6 – 95.1]	1.0	
Yes	35	6.1 [4.4 – 8.4]	28	7.2 [4.9 – 10.4]	1.2 [0.7 – 2.0]	

† Data have been weighted to correct for non-response bias, and for clustering in the household survey. Analysis accounts for the survey design and the weighting. Sample sizes are unweighted.

†† This included either meeting the cut off score of 12 in the CIS-R or screening positive on the PTSD screen.

††† The cut off score defining cases for the CIS-R score is 12, the threshold determined by Lewis et al based on comparisons with the General health Questionnaire and psychiatric interviewers (Lewis et al, 1992).

†††† This variable was created by amalgamating the 12 primary diagnoses identified from CIS-R scores according to ICD-10 disorders:

- No disorder
- Neurotic, stress-related, and somatoform disorders: non-specified neurotic disorder, generalised anxiety disorder mild, generalised anxiety disorder, obsessive compulsive disorder, mixed anxiety and depressive disorder, specific (isolated) phobia, social phobia, agoraphobia, panic disorder.
- Depressive Disorders: mild depressive episode, moderate depressive episode, severe depressive episode.

††††† This screen identifies a possible case of PTSD if the participant responds positively to three or more items in the screen.

3.4.5.2 Association of individual characteristics with psychological symptoms

In the univariate analysis, being unemployed or having a long standing physical condition was found to increase the risk of experiencing high levels of psychological symptoms (significant at the $p<0.05$ level). Having a household monthly gross income of £1,593 or more (compared to earning £0 - £420 per month), being educated at a higher degree level, being married or cohabiting, having a larger social network, or having a high level of social support was found to be protective against psychological symptoms (significant at the $p<0.05$ level) (see Table 9). The effect of social support on psychological symptoms was stronger for having someone to talk to or give you company (OR: 0.3 [95% CI: 0.2 – 0.6]), or to make you feel good, loved, or cared for (OR: 0.2 [95% CI: 0.1 – 0.4]) than for having someone to lend you money (OR: 0.7 [95% CI: 0.4 – 1.0]). Help in dealing with an emergency was not associated with high levels of psychological symptoms (OR: 1.0 [95% CI: 0.5 – 1.7]) (not shown in Table 9).

Table 9 Association of individual characteristics with psychological symptoms†

Variable	n	Prevalence of high levels of symptoms ††		Unadjusted OR [95% CI]	p-value
		n	%, [95% CI]		
Socio-demographic characteristics					
Age , years (n=938)	938	309		0.99 [0.99 – 1.00]	*0.20*
Mean (S.E.) [95%CI]			42.1 (1.2) [39.9 – 44.4]		
Median (25th and 75th percentiles)			38 (26, 50)		
(Range)			(16-81)		
Ethnic category (n=937)					
White	572	166	28.4 [24.7 – 32.4]	1.0	---
Black Caribbean	88	32	37.8 [27.5 – 49.4]	1.5 [0.9 – 2.6]	*0.10*
Black African	132	33	24.9 [17.9 – 33.6]	0.8 [0.5 – 1.3]	*0.46*
Asian and Other	145	44	29.5 [22.8 – 37.1]	1.1 [0.7 – 1.6]	*0.79*
Relationship status (n=938)					
Single	358	113	31.1 [26.4 – 36.3]	1.0	
Married/cohabiting	409	102	24.1 [20.1 – 28.6]	0.7 [0.5 – 1.0]	*0.04**
Divorced/separated/widowed	171	60	35.0 [28.0 – 42.6]	1.2 [0.8 – 1.8]	*0.38*
Number of Children (938)	938	275		1.0 [0.9 – 1.1]	*0.52*
Mean (S.E.) [95%CI]			1.6 (0.1) [1.4 – 1.9]		
Median (25th and 75th percentiles)			1 (0, 2)		
(Range)			(0-9)		
Socio-economic status					
Household monthly gross income category (n=802)					
£0 - £420	85	37	43.0 [32.7 – 53.9]	1.0	
£421 - £928	129	43	31.2 [23.8 – 39.8]	0.6 [0.3 – 1.1]	*0.08*
£929 - £1,592	123	48	38.7 [30.4 – 47.6]	0.8 [0.5 – 1.5]	*0.54*
£1,593 - £2,416	97	26	25.9 [17.5 – 36.7]	0.5 [0.2 – 0.9]	*0.02**
£2,417 or more	368	80	21.4 [17.5 – 25.9]	0.4 [0.2 – 0.6]	*<0.001***
Employment Status (n=934)					
In paid employment	512	130	24.7 [21.1 – 28.7]	1.0	---
Unemployed	90	39	43.5 [33.3 – 54.3]	2.3 [1.5 – 3.8]	*<0.001****
Economically inactive	251	83	32.3 [26.7 – 38.5]	1.5 [1.0 – 2.0]	*0.03**
At home looking after children	81	22	26.6 [18.1 – 37.2]	1.1 [0.6 – 1.9]	*0.72*
Education level (n=925)					
No qualification	122	45	33.3 [25.6 – 42.1]	1.0	---

GCSE or A-level of equivalent	420	136	32.1 [27.7 – 36.9]	0.9 [0.6 – 1.4]	*0.81*
Degree level or above	383	88	22.8 [18.8 – 27.5]	0.6 [0.4 – 0.9]	*0.02**
Physical health					
Long standing condition (n=932)					
Not present	562	127	22.4 [19.1 – 26.2]	1.0	
Present	370	144	36.6 [31.7 – 41.8]	2.0 [1.5 – 2.7]	*<0.001***
Social resources					
Social support (n=927)					
Low support	69	33	46.5 [35.0 – 58.3]	1.0	
High support	858	233	26.7 [23.7 – 29.9]	0.4 [0.3 – 0.7]	*0.001***
Social network size (n=935)	935	272		0.8 [0.8 – 0.9]	*<0.001****
Mean (S.E.) [95%CI]			4.5 (0.1) [4.2 – 4.7]		
Median (25th and 75th percentiles)			4 (3, 6)		
(Range)			(0-9)		

† Data have been weighted to correct for non-response bias, and for clustering in the household survey. Analysis accounts for the survey design and the weighting. Sample sizes, medians, quartiles, and ranges are unweighted.

†† This included either meeting the cut off score of 12 in the CIS-R or screening positive on the PTSD screen.

* p<.05 ** p<.01 *** p<.001

3.4.5.3 Risk of psychological symptoms in women with a history of stressful life events

Childhood stressful life events: Both potentially traumatic and other childhood stressful life events were found to increase the risk of experiencing high levels of psychological symptoms. Spending time in an institution, being taken into local authority care, a major accident or illness, being separated from parents, physical abuse, and sexual abuse were all found to significantly increase the risk of experiencing high levels of psychological symptoms. After correcting for multiple testing, all of these variables remained significant. (See Table 10).

Lifetime stressful life events: Both potentially traumatic and other lifetime stressful life events were found to increase the risk of experiencing high levels of psychological symptoms. The end of a relationship following cohabitation, the death of a loved one, witnessing violence, a serious accident, homelessness, being the victim of a serious crime, being injured with a weapon, and physical or sexual abuse were found to significantly increase the risk of psychological symptoms. After correcting for multiple testing, all of these variables remained significant. (See Table 11).

Table 10 Risk of psychological symptoms following childhood stressful life events†

Variable	n	Prevalence of high levels of symptoms ††		Unadjusted OR [95% CI]	*p-value (uncorrected)*	*Significance level (correction for multiple testing)*
		n	%, [95% CI]			
Potentially traumatic childhood stressful life events (n=927)					*<0.001****	
Not experienced	593	125	20.9 [17.7 – 24.5]	1.0		
Experienced	334	142	41.3 [35.8 – 46.9]	2.7 [2.0 – 3.6]		
Major accident or illness (n=935)					*0.002**	*p<0.008**
Experienced	736	196	26.2 [23.0 – 29.6]	1.0		
Not experienced	199	77	37.8 [31.0 – 45.1]	1.7 [1.2 – 2.4]		
Physical abuse (n=933)					*<0.001****	*p<0.006**
Experienced	754	181	23.6 [20.6 – 26.9]	1.0		
Not experienced	179	90	49.9 [42.3 – 57.5]	3.2 [2.3 – 4.6]		
Sexual abuse (n=929)					*<0.001****	*p<0.007**
Experienced	871	230	26.0 [23.1 – 29.2]	1.0		
Not experienced	58	38	63.7 [50.0 – 75.5]	5.0 [2.7 – 8.5]		
Other childhood stressful life events (n=931)					*0.003***	
Not experienced	523	132	24.9 [21.3 – 28.8]	1.0		
Experienced	408	140	33.9 [29.2 – 38.9]	1.5 [1.2 – 2.1]		
Spend time in an institution (n=938)					*0.006***	*p<0.01**
Experienced	903	257	28.1 [25.1 – 31.2]	1.0		
Not experienced	35	18	50.8 [34.5 – 67.0]	2.7 [1.3 – 5.3]		
Taken into Local Authority Care (n=938)					*0.001***	*p<0.01**
Experienced	906	256	27.9 [25.0 – 31.1]	1.0		
Not experienced	32	19	56.5 [38.8 – 72.7]	3.4 [1.6 – 7.0]		
Parental divorce (n=934)					*0.28*	---
Experienced	774	221	28.2 [24.9 – 31.7]	1.0		
Not experienced	160	53	32.5 [25.7 – 40.1]	1.2 [0.8 – 1.8]		
Death of parents (n=931)					*0.17*	*p<0.03*
Experienced	837	239	28.0 [24.9 – 31.3]	1.0		
Not experienced	94	33	35.2 [25.7 – 45.9]	1.4 [0.9 – 2.2]		
Separation from parents (n=948)					*0.01**	*p<0.02**
Experienced	585	152	25.8 [22.3 – 29.6]	1.0		

Not experienced	348	120	33.7 [28.7 – 39.1]	1.5 [1.1 – 2.0]		

† Data have been weighted to correct for non-response bias, and for clustering in the household survey. Analysis accounts for the survey design and the weighting. Sample sizes, medians, quartiles, and ranges are unweighted.

†† This included either meeting the cut off score of 12 in the CIS-R or screening positive on the PTSD screen.

* p<.05 ** p<.01 *** p<.001

Table 11 Risk of psychological symptoms following lifetime stressful life events†

Variable	N	Prevalence of high levels of symptoms ††		Unadjusted OR [95% CI]	*p-value (uncorrected)*	*Significance level (correction for multiple testing)*
		n	%, [95% CI]			
Potentially traumatic lifetime stressful life events (n=931)					*<0.001***	
Not experienced	288	48	15.8 [12.1 – 20.4]	1.0		
Experienced	643	221	34.0 [30.2 – 38.0]	2.7 [1.9 – 3.9]		
Serious accident (n=935)					*0.01**	*p<0.01**
Not experienced	762	209	26.9 [23.7 – 30.2]	1.0		
Experienced	173	63	36.7 [29.5 – 44.6]	1.6 [1.1 – 2.3]		
Exposure to conflict (n=935)					*0.32*	*p<0.02*
Not experienced	826	235	28.1 [25.0 – 31.4]	1.0		
Experienced	109	37	32.9 [24.3 – 42.7]	1.3 [0.8 – 2.0]		
Witnessing violence (n=934)					*<0.001****	*p<0.006**
Not experienced	600	137	22.2 [18.9 – 25.8]	1.0		
Experienced	334	134	40.8 [35.4 – 46.3]	2.4 [1.8 – 3.3]		
Being the victim of a serious crime (n=935)					*<0.001****	*p<0.008**
Not experienced	608	144	23.2 [19.9 – 26.9]	1.0		
Experienced	327	128	38.5 [33.2 – 44.1]	2.1 [1.5 – 2.8]		
Being injured with a weapon (n=935)					*<0.001****	*p<0.004**
Not experienced	870	231	26.0 [23.0 – 29.2]	1.0		
Experienced	65	41	63.5 [50.6 – 74.7]	5.0 [2.9 – 8.6]		
Physical or sexual abuse (n=932)					*<0.001****	*p<0.006**
Not experienced	678	138	20.1 [17.2 – 23.5]	1.0		
Experienced	254	132	51.7 [45.3 – 58.1]	4.2 [3.1 – 5.8]		
Other lifetime stressful life events (n=923)					*<0.001****	
Not experienced	238	47	18.9 [14.4 – 24.4]	1.0		
Experienced	685	221	31.6 [28.1 – 35.4]	2.0 [1.4 – 2.9]		
End of a relationship following cohabitation (n=935)					*<0.001****	*p<0.007**
Not experienced	585	134	21.9 [18.6 – 25.5]	1.0		
Experienced	350	138	39.8 [34.6 – 45.3]	2.4 [1.8 – 3.2]		
Death of a loved one (n=934)					*0.03**	*p<0.01**
Not experienced	415	105	24.7 [20.7 – 29.2]	1.0		

Experienced	519	167	31.5 [27.5 – 35.9]	1.4 [1.0 – 1.9]		
Homelessness (n=935)					*<0.001***	*p<0.005**
Not experienced	884	240	26.7 [23.8 – 29.9]	1.0		
Experienced	51	32	62.0 [47.5 – 74.7]	4.5 [2.4 – 8.2]		
Serious illness or accident of a child (n=925)						---
Not experienced	824	242	28.9 [25.7 – 32.2]	1.0	*0.73*	
Experienced	101	27	27.2 [19.1 – 37.0]	0.9 [0.6 – 1.5]		
Having a child with special needs (n=925)						---
Not experienced	858	251	28.7 [25.7 – 32.0]	1.0	*0.88*	
Experienced	67	18	27.8 [18.1 – 40.2]	1.0 [0.5 – 1.7]		

† Data have been weighted to correct for non-response bias, and for clustering in the household survey. Analysis accounts for the survey design and the weighting. Sample sizes, medians, quartiles, and ranges are unweighted.

†† This included either meeting the cut off score of 12 in the CIS-R or screening positive on the PTSD screen.

* p<.05 ** p<.01 *** p<.001

3.4.6 Multivariate analysis of the relationship between migration and psychological symptoms

3.4.6.1 Effect of migration and stressful life events on psychological symptoms

The hypothesis that first generation migrant women would be significantly more likely to experience high levels of psychological symptoms compared with women born in the UK, after controlling for potential confounders, was rejected, as migrant status was not found to be significantly associated with an increase in psychological symptoms, and there was no significant confounding by any of the individual variables examined (see Table 12 and Table 13). In the final model, experiencing potentially traumatic childhood or lifetime stressful life events, other lifetime stressful life events, and long standing physical conditions were found to be significantly associated with an increased risk of experiencing high levels of psychological symptoms. Women who were older, identified as Black African, had high levels of social support, or an increased social network size were found to have a decreased risk of psychological symptoms.
(See Table 13).

Table 12 Association of migration with psychological symptoms†

Variable (covariates)	n	Odds Ratio	[95% CI]	*p-value*
Migration	938	1.1	[0.8 – 1.4]	*0.77*
Migration adj for age	938	1.0	[0.8 – 1.4]	*0.81*
Migration adj for age + ethnicity	937	1.1	[0.8 – 1.5]	*0.71*
Migration adj for age + relationship status	938	1.0	[0.8 – 1.4]	*0.85*
Migration adj for age + number of children	938	1.0	[0.7 – 1.3]	*0.91*
Migration adj for age + household monthly gross income category	802	0.9	[0.7 – 1.3]	*0.71*
Migration adj for age + employment status	934	1.0	[0.8 – 1.4]	*0.84*
Migration adj for age + education level	925	1.0	[0.8 – 1.4]	*0.93*
Migration adj for age + long standing conditions	932	1.0	[0.8 – 1.4]	*0.80*
Migration adj for age + social support	927	1.0	[0.7 – 1.3]	*0.81*
Migration adj for age + social network size	935	1.0	[0.7 – 1.3]	*0.82*
Migration adj for age + potentially traumatic childhood stressful life events	927	1.0	[0.7 – 1.4]	*0.93*
Migration adj for age + other childhood stressful life events	931	1.0	[0.7 – 1.4]	*0.99*
Migration adj for age + potentially traumatic lifetime stressful life events	931	1.0	[0.8 – 1.4]	*0.82*
Migration adj for age + other lifetime stressful life events	923	1.0	[0.7 – 1.4]	*0.99*
Migration adj for all covariates	755	1.1	[0.7 – 1.6]	*0.82*

† Data have been weighted to correct for non-response bias, and for clustering in the household survey.

Table 13 Fully adjusted model: Risk factors for high levels of psychological symptoms (n=755) †

Variable (covariates)	Adjusted Odds Ratio	[95% CI]	*p-value*
Migration	1.0	[0.7 – 1.6]	*0.84*
Age	1.0	[1.0 – 1.0]	*<0.001***
Ethnic Category (white = reference)			
Black Caribbean	0.7	[0.3 – 1.3]	*0.23*
Black African	0.5	[0.3 – 1.0]	*0.03**
Asian and Other	0.8	[0.4 – 1.3]	*0.29*
Relationship Status (single = reference)			
Married/cohabiting	0.9	[0.5 – 1.4]	*0.55*
Divorced/separated/widowed	1.4	[0.8 – 2.5]	*0.21*
Number of children	1.1	[0.9 – 1.3]	*0.34*
Household Monthly Gross Income Category (£0 - £420 = reference)			
£421 - £928	0.6	[0.3 – 1.1]	*0.11*
£929 - £1,592	1.1	[0.6 – 2.1]	*0.75*
£1,593 - £2,416	0.7	[0.3 – 1.5]	*0.33*
£2,417 or more	0.6	[0.3 – 1.5]	*0.16*
Employment (in paid employment = reference)			
Unemployed	0.9	[0.5 – 1.7]	*0.70*
Economically inactive	0.8	[0.5 – 1.3]	*0.41*
At home looking after children	0.7	[0.3 – 1.5]	*0.36*
Education level (no qualification = reference)			
GCSE or A-level or equivalent	0.8	[0.4 – 1.5]	*0.50*
Degree level or above	0.6	[0.3 – 1.3]	*0.18*
Long standing physical condition	1.8	[1.2 – 2.7]	*0.004***
Social support (low = reference)	0.4	[0.2 – 0.9]	*0.02**
Social network size	0.8	[0.8 – 0.9]	*0.001***
Potentially traumatic childhood stressful life events	1.8	[1.2 – 2.7]	*0.002***
Other childhood stressful life events	1.2	[0.8 – 1.7]	*0.47*
Potentially traumatic lifetime stressful life events	2.0	[1.3 – 3.1]	*0.002***
Other lifetime stressful life events	1.7	[1.1 – 2.8]	*0.03**

† Data have been weighted to correct for non-response bias, and for clustering in the household survey.
* p<.05 ** p<.01 *** p<.001

3.5 Discussion

3.5.1 Main findings

There was a high prevalence of psychological symptoms (28.9% [95% CI: 26.0 – 32.1]) identified in this population of women living in South East London compared with the national average [7]. However, there was no significant difference in the risk of experiencing high levels of psychological symptoms for first generation migrant women compared with women born in the UK. The significant predictors of psychological symptoms were potentially traumatic childhood and lifetime stressful life events, other lifetime stressful life events, and long term physical conditions, consistent with previous research into predictors of poor mental health [243, 350, 364-367].

The predictors, which are highly prevalent among migrant women and women born in the UK in this sample (see Table 5, Table 6, and Table 7), may explain why the proportion of women with high levels of psychological symptoms in this study is higher than the national average. 27.3% [95% CI: 24.4 – 30.4] of women in this population had a high level of symptoms for common mental disorders, and 6.4% [95% CI: 5.0 – 8.2] met the criteria for possible PTSD. In the 2007 Adult Psychiatric Morbidity Survey in England, 19.7% of women were found to have a significant level of symptoms of common mental disorder (measured using the CIS-R, cut-off of 12), and 3.3% of women screened positive for PTSD (using the Trauma Screening Questionnaire, cut-off of 6 out of 10 items experienced at least twice in the past week) [7].

Migrant women were not found to experience a higher prevalence of stressful life events or long term physical conditions than women born in the UK, which may contribute to the findings in this study that there was no significant difference in the risk of experiencing high levels of psychological symptoms between migrant women and women born in the UK. However, research has found a high prevalence of exposure to stressful life events among some migrant women (e.g. refugees and asylum seekers) [71, 158, 368], and pointed to specific groups of migrants who may be at increased risk, for example based on reason for migration or country of origin [15-18, 26, 27, 46, 47, 158, 368, 369].

The context of migration and the characteristics of migrants can vary greatly [19, 131, 370], and the lack of consensus in previous research regarding the relationship between migration and psychological symptoms may be due to differences in risk across migrant populations [371]. This heterogeneity may also have contributed to the negative findings in this study. Differences in risk among migrant women will be explored further in subsequent chapters.

The lack of a significant relationship between migration and psychological symptoms in this study may also be due to the study setting, for example community level factors in South East London (ethnic density, socio-economic deprivation, access to services) [372]. The individuals represented in this sample may be more likely to be living in deprived circumstances than individuals in other parts of the UK, which may contribute to the high prevalence of psychological symptoms in this population. Geographical context

may also contribute to contradictory findings across studies regarding the effect of migration on mental health [372].

Alternatively, migrant women may not have higher levels of psychological symptoms if they experience more protective factors (for example, are more likely to be well supported within their communities than the native population). Being married or cohabiting, social support and increased social network size (which may be associated with help in accessing services, assisting with roles or responsibilities, companionship or providing care), and older age were found to be protective, in line with the literature [46, 102, 373, 374]. Migrant women were found to be more likely to be (or have been) married or cohabiting compared with women born in the UK. However, women born in the UK were more likely to have high levels of social support as measured by the number of people they could get help or assistance from if needed.

It is interesting to note that there was no difference between migrant women and women born in the UK in levels of emotional support. However, women born in the UK were significantly more likely to have instrumental support. The effect on psychological symptoms was stronger for emotional support than instrumental support, which may explain why this did not contribute to a difference in risk between migrant women and women born in the UK. This reflects previous research. For example in a cross-sectional study of 200 Korean migrants in the US, Lee et al identified that emotional support was a more important resource than instrumental support, moderating the effects of life stress on depression [375]. In their cross-sectional survey of 336 women with breast cancer, Bloom et al identified that emotional support was significantly associated with better mental well-being, while instrumental support was only found to be marginally significant (p=0.097), and was inversely associated with mental well-being [376].

3.5.2 Strengths and limitations

3.5.2.1 Strengths

This study has several strengths. First, it includes data for a large and diverse sample of migrant women and women born in the UK, including women from diverse linguistic backgrounds. While much research excludes non-English speaking participants [287, 290,

[293, 294], this study aimed to include women living in South East London with limited English proficiency.

There is a gap in research examining differences in exposure to risk factors or the risk of experiencing symptoms of common mental disorders or PTSD between migrant and non-migrant women (see chapter 1, page 11). This study contributes to existing research by comparing exposure to stressful life events and the risk of experiencing high levels of psychological symptoms for migrant women and women born in the UK.

3.5.2.2 Limitations

3.5.2.2.1 Examining the relationship between migration and mental health

This analysis aimed to examine the risk of experiencing high levels of psychological symptoms for first generation migrant women compared to women born in the UK living in South East London. However, categorising all migrants as one group and not acknowledging the heterogeneity of the migrant population limited the analysis, as differences in risk across migrants could not be explored. Further analysis is needed to explore what groups of migrant women may be at increased risk (see chapter 4, page 134).

A further limitation is that the nature of cross-sectional data means it is not possible to establish whether symptoms were experienced prior to migration or if symptoms developed following migration, so that no conclusions can be drawn on the direction of the association. This is a limitation of the majority of research on the mental health of migrants, as it is difficult to do a longitudinal study which evaluates mental health prior to the decision to migrate, and following arrival and integration in the destination country.

3.5.2.2.2 Generalisability of findings

Data from this study only provide information about a specific population. While the findings may be relevant to the population in South East London, they cannot be assumed to be representative of the general population. Furthermore, there are specific limitations that may have limited the generalisability of the findings.

Specific inclusion and exclusion criteria are necessary for any study; however, it is important to acknowledge that they ultimately affect who is represented. The SELCoH Study is a household survey, and thus data were only collected on individuals living in private residences in South East London. This means that no data were obtained on individuals who are homeless, or living in temporary accommodation, student accommodation, hostels, assisted living facilities, or other non-private situations (e.g. detention centres). This may be particularly relevant to a migrant population that, for reasons of legal status, socio-economic status, or being recent arrivals, may not have an established main residence, may have multiple residences, or may be frequently moving [323]. Consequently, only more settled or permanent migrants may be represented.

Recruitment methods also affect who is represented. Attempts were made to recruit all members of each household in the SELCoH study. However, not all household members, for example, may have received information about or been informed of the study, and not all individuals in a household may have been given an equal opportunity to participate. For example, women who are in situations where they have limited interactions with people outside the home or are unable to invite people into their home may not be represented. This may be particularly true for women experiencing domestic violence, including women living in a situation where a partner or other family members control this aspect of their lives.

Language may have also presented barriers to recruitment and participation, and consequently the representativeness of the survey (for a discussion of cross-language methodological issues see chapter 2, page 50). This is particularly important to recognise for the present study focusing on migrant women. The SELCoH Study made provisions to enable non-English speaking individuals to participate by providing an interpreter for the survey where needed or requested. However, recruitment was conducted through letters sent to households, phone calls, and house visits, and initial contact with potential participants was conducted in English. In some cases, other members of a household may have been able to translate the introduction letter or information sheet mailed to an address for non-English speaking household members, or to interpret for researchers during house visits or phone calls. However, it may be that some individuals were not able to or chose not to engage in the study because of real or perceived language barriers.

Migrant status may also have impacted on who chose to participate. Mistrust, fear of contact with authorities or of interview situations (relating to previous experiences in refugee facilities, detention centres, legal processes, etc), objections to signing consent forms or legal obligations, fear of stigmatisation, worries relating to the jeopardisation of migrant status through participation, and lack of confidence in the anonymity or confidentiality of research may present barriers to participation, particularly for migrant communities [305, 323, 377]. Although the participation in the SELCoH study was confidential, these concerns may still have limited who was represented. Overall, however, the proportion of migrants included in the survey was similar to the proportion reported in the 2011 UK Census [347] (though these issues may also be relevant to the Census).

These barriers are difficult to overcome in a large survey (e.g. household surveys using random sampling and structured questionnaires) due to time, funding, training, ethical concerns (e.g. vulnerable populations, coercion, risk to researchers etc), and the overall research aims [378]. In order to enable these populations to be represented in research, methodologies specifically focused on these populations (e.g. specific training for researchers, targeting relevant locations like shelters for recruitment, appropriate cross-language methods) can be used to supplement larger surveys [378-381].

While these barriers may have impacted on the generalisability of the data in the SELCoH study, the household participation rate for this survey was 51.9%, and 71% of eligible individuals within these households were interviewed, suggesting the majority of household members participated in the survey. Though not directly comparable, this can be considered in the context of other studies, for example the 2007 Adult Psychiatric Morbidity Survey where 57% of eligible individuals randomly chosen from each selected household agreed to participate in phase one of their study [7].

3.5.2.2.3 Data limitations

Data limitations may also have impacted on how representative the findings are. Language, for example, may not only have presented barriers to participation, but may also have affected the data collected. For example, differences in the interpretation of questions, or of responses, as well as inconsistencies generated through translation may compromise data (see chapter 2, page 50).

Differences in interpretation can also occur due to cultural, not only linguistic, differences. Though the measures in this study have been validated in diverse populations, it is still important to reflect on the cross-cultural sensitivity and validity of any instrument [30]. Biomedical or Western instruments measuring psychiatric symptoms in non-Western populations (as in this study) may not be accurate due to differences in explanatory models or conceptualisations of illness across cultures [64, 269-274, 382].

Migrant status may also affect self-reported data (e.g. specific misreporting in migrant women). For example data on work status, household income, and stressful life events have been shown to be difficult to capture across populations [383-386], and may represent sensitive information. For migrant women specifically (for example participants with insecure legal status), the divulgence of this information may be affected if the participant has a concern about who has access to this information, what information they should 'officially' report, consistency in reporting between household members if multiple individuals in a household elect to participate, etc [323, 377, 384]. Though participants were reassured of the confidentiality and anonymity of their participation in the SELCoH Study, these concerns could still impact on what information was disclosed.

3.5.3 Conclusions

Exposure to potentially traumatic stressful life events was found to increase the risk of psychological symptoms for both migrant women and women born in the UK. Furthermore, a large proportion of women in the sample were found to have experienced potentially traumatic lifetime stressful life events. This may have contributed to the finding that a substantial proportion of migrant women and women born in the UK in the sample experience high levels of psychological symptoms. Overall, first generation migrant women were not found to be significantly more likely to experience high levels of psychological symptoms than women born in the UK living in South East London.

This finding may be due to differences in risk among migrant women. The context of migration, including both individual and environmental factors, and when risk factors are experienced (pre or post-migration) can impact on migrant women's mental health, and an ecological model should inform research on migration and mental health [19, 339,

[387, 388]. However, few studies adequately explore relevant contextual factors when examining differences in risk across migrant women. Applying an ecological model, the next chapter explores how pre-migration macro-level factors and individual migration specific factors may contribute to differences in the risk of experiencing high levels of psychological symptoms among migrant women.

Chapter 4: The relationship between migration and psychological symptoms for women in South East London: Exploratory study of the effect of pre-migration macro-level factors and individual level migration specific factors on the risk of psychological symptoms

4.1 Introduction

The results presented in the previous chapter suggest that there is no significant difference in the risk of experiencing high levels of psychological symptoms between first generation migrant women and women born in the UK living in London. However, migrants are not a homogenous group and some groups of migrants may be at increased risk [371, 389, 390]. Differences in risk among migrants may be explained by factors occurring at multiple ecosystemic levels and at different stages of migration [19, 59, 339, 387]. In this chapter, an ecological model is used to explore how macro-level factors in women's countries of origin (e.g. pre-migration) and individual level factors occurring during migration may contribute to differences in the risk of experiencing high levels of psychological symptoms.

4.2 Analysis I: Pre-migration macro-level factors

Macro-level (systemic or environmental) factors, including geographic origin, gross national product, and levels of development or gender disadvantage, have been found to be associated with individual mental health [19, 339, 387]; low levels of development, and high levels of gender disadvantage in one's country of origin, for example, have been found to be associated with increased levels of psychological symptoms, and women in low-income countries have been shown to be at increased risk of experiencing high levels of psychological symptoms compared to men [19, 339, 369, 387, 391-397]. These macro-level factors may reflect individual level factors shown to be associated with psychological symptoms including levels of deprivation, access to education, health services, resources like food, water, and housing, or roles (e.g. social, political, or economic roles accessible to women) [33, 398-402], and may also be associated with other risk factors including exposure to conflict, political violence, domestic or sexual violence, trafficking, or witnessing violence[33, 157, 398, 400, 401, 403-405]. Though patterns of migration often reflect a flow from less developed to more developed countries [406], and

though the countries of origin of migrant populations in developed countries (e.g. the UK) represent a range of development levels, there is limited research that explores whether these factors contribute to differences in risk among migrant women and women born in receiving countries [407].

This analysis explores whether migrant women may be at increased risk of experiencing high levels of psychological symptoms due to macro-level factors compared to women born in the UK. Specifically, this analysis examines the effect of the inequality-adjusted human development level (using the UN's Inequality-adjusted Human Development Index (IHDI)) and gender inequality level (using the UN's Gender Inequality Index (GII)) of women's countries of origin on psychological symptoms [408].

The IHDI is an indicator of country-level distributions of education, health status, and living standards, accounting for inequalities in these dimensions. The GII provides insight into health, empowerment, and labour, accounting for gender inequalities, which are particularly relevant in research with migrant women. These specific indices were selected for several reasons, and distinguish this analysis from previous research.

Previous research has used other macro-level indicators (e.g. the Human Development Index (HDI), Gross National Product (GNP), the Generalised Inequality Index (Gini Index), the Gender-Related Development Index (GDI), and the Gender Empowerment Measure (GEM)) to examine the relationship between country-level development status, socio-economic status, gender inequalities, and individual physical and mental health [6, 369, 394, 409]. However, findings have not been consistent, which may be due to the limitations of these measures.

Many indices do not sufficiently account for a range of factors (e.g. social indicators) shown to affect mental health [410-412]. The IHDI and GII capture multiple macro-level factors shown to be associated with psychological symptoms, including health, education, and standard of living [33, 334, 398-402]. The IHDI and GII also account for inequalities, which many measures do not (e.g. GNP or the HDI). It is important to use measures which adjust for inequalities because of their association with poor mental health [6, 334, 400], and because a skewed distribution of factors like income, education, health, and living standards may misrepresent the status of individuals whose circumstances may not be reflected at the country level [43, 413, 414].

Many indices are calculated using data that may not be available or consistent for all countries and thus may not be internationally uniform or applicable. The IHDI and GII are inclusive of a greater number of countries than other indicators (e.g. GEM, Social Institutions and Gender Index (SIGI)) [408, 415, 416], and were developed recently to improve upon and serve as more informative, consistent, and appropriate measures than other indicators (HDI, GDI, GEM) [6, 411]. Additionally, some indices are also not constructed in a way that facilitates using them independently. For example, the GDI was developed to be used with (not independent of) the HDI. The IHDI and GII can both be used independently, and are also complementary of each other, as they utilise similar frameworks [408] (See 4.2.3.2.1).

The IHDI and GII are thus more comprehensive and appropriate indicators of country-level development, quality of life, and inequality than other income-based or development measures [413, 414, 417], and I therefore chose to use these macro-level indicators for the purposes of this exploratory analysis.

4.2.1 Objectives

The specific objectives of this analysis are to:

Use cross-sectional data (from the SELCoH Study) to investigate differences in the risk of experiencing high levels of psychological symptoms between first generation migrant women and women born in the UK living in London due to macro-level factors, including the inequality-adjusted human development level of women's countries of origin, and the level of gender-inequality in women's countries of origin.

4.2.2 Hypothesis

As this is an exploratory analysis, there are no hypotheses being tested.

4.2.3 Methods

4.2.3.1 Study population

The study compares first generation migrant women and women born in the UK who participated in the SELCoH Study. The inclusion and exclusion criteria are consistent with the previous study (see chapter 3, section 3.3.1.1, page 94).

4.2.3.2 Covariates

4.2.3.2.1 Pre-migration macro-level variables

Inequality-adjusted Human Development Index: Countries of birth are scored using the 2011 United Nations Inequality-adjusted Human Development Index (IHDI) [408]. Higher scores indicate higher human development levels (adjusted for levels of inequality determined using the Atkinson index), and include the following dimensions:

- Health: inequality in distribution of life expectancy at birth. Data from the United Nations Department of Economic and Social Affairs 'World Population Prospects' (2011).
- Education: inequality in distribution of mean years of schooling. Data from the Luxembourg Income Study (2009), EUROSTAT's 'European Union Statistics on Income and Living Conditions' (2010), the World Bank's 'International Income Distribution Database' (2010), the United Nations Children's Fund's 'Multiple Indicators Cluster Surveys' (2000-2010), ICF Macro's 'Measure DHS (Demographic and Health Survey)' (2011), the World Health Organization's 'World Health Survey' (2000-2010), and the United Nations University and World Institute for Development Economics Research 'World Income Inequality Database' (2008).
- Living standards: inequality in distribution of disposable household income or consumption per capita. Data come from the databases and surveys listed above for 'education'.

Categories were created according to quartiles for the IHDI scores and included: born in the UK (a high IHDI level country), and high, medium, low, and very low IHDI level countries of origin for migrant women in the sample. All very low IHDI level countries were in Africa; low IHDI level included countries in Africa, the Middle East, Asia, and Central and South America; medium IHDI level included countries in Central and South America, the Caribbean, and Eastern Europe; and high IHDI level included countries in Western Europe, Northern Europe, and North America (see Table 14).

Table 14 Countries of origin by IHDI level

High IHDI level countries (n)	Medium IHDI level countries (n)	Low IHDI level countries (n)	Very low IHDI level countries (n)
Australia (11)	Argentina (1)	Bangladesh (3)	Angola (3)
Austria (2)	Bulgaria (1)	Bolivia (1)	Burundi (1)
Canada (8)	Chile (6)	Brazil (6)	Cameroon (1)
Czech Republic (1)	Costa Rica (1)	China (16)	Ethiopia (3)
Denmark (1)	Cyprus (5)	Columbia (9)	Ghana (23)
Finland (1)	Ecuador (5)	Egypt (3)	Guinea Bissau (2)
France (10)	Jamaica (39)	Guyana (5)	Ivory Coast (2)
Germany (11)	Lithuania (2)	India (7)	Malawi (2)
Greece (1)	Mexico (2)	Kenya (2)	Nigeria (46)
Holland (2)	Poland (5)	Morocco (1)	Senegal (1)
Hungary (2)	Portugal (12)	Pakistan (7)	Sierra Leone (12)
Ireland (13)	Romania (3)	Philippines (5)	Tanzania (1)
Italy (6)	Russia (5)	South Africa (9)	Uganda (2)
Slovakia (4)	Serbia (1)	Thailand (2)	Zambia (1)
Spain (10)	Ukraine (3)	Tunisia (1)	Zimbabwe (1)
Sweden (1)		Turkey (5)	
Switzerland (1)		Venezuela (1)	
United States (6)			

The countries of origin for 31 migrant women in the SELCoH study are not included in the UN Inequality-adjusted Human Development Index as data were not available from these countries for the relevant dimensions (see Table 15). These women were not included in the IHDI analyses. Omission of scores for countries was not based on development level (e.g. when compared to the standard UN Human Development Index [408]), and thus the results are not biased due to this.

Table 15 Countries of origin omitted from the Inequality-adjusted Human Development Index (n=31)

Country of origin	Number of women in sample
Afghanistan	1
Algeria	1
Barbados	1
Eritrea	5
Grenada	2
Hong Kong	2
Iran	1
Iraq	1
Japan	1
Kosovo	1
Malaysia	1
Mauritius	2
New Zealand	7
Saudi Arabia	1
Singapore	1
Somalia	1
Taiwan	2

Gender Inequality Index: Countries of origin for migrant women in the sample were also scored using the 2011 United Nations Gender Inequality Index (GII) [408]. Higher scores indicate higher levels of gender inequality, and are based on indicators of development, adjusted for three dimensions, and a total of five indicators:

- Reproductive health:
    - Maternal mortality: number of maternal deaths per number live births per year. Data from the World Health Organization, United Nations Children Fund, United Nations Population Fund, World Bank 'Trends in Maternal Mortality (2010);
    - Adolescent fertility rate: number of births among women aged 15-19. Data from the United Nations Department of Economic and Social Affairs 'World Population Prospects' (2011).
- Empowerment:
    - Parliamentary representation: percentage of total seats held by women. Data from the Inter-parliamentary Union's 'women in National Parliaments: World Classification' (2011).
    - Educational attainment to secondary level and above: proportion of population 25 or older with this level of education. Data from the United nations Human Development Report (2011) updates for 'Barro-Lee Dataset' based on United Nations Educational, Scientific and Cultural Organization 'UNESCO Institute for Statistics: Data Centre' (2010).
- Labour market: labour force participation (ratio of proportion of women in working age population in labour market compared to proportion of men). Data from the International Labour Organization 'Key indicators on the labour market' (2011).

Categories were created according to quartiles for the GII scores and included: Born in the UK (low levels of gender inequality), and very high, high, medium, and low levels of gender inequality for the countries of origin of migrant women in the sample. The countries included in each GII level are displayed in Table 16.

Table 16 Countries of origin by GII level

Very high GII level (n)	High GII level (n)	Medium GII level (n)	Low GII level (n)
Afghanistan (1)	Algeria (1)	Argentina (1)	Australia (11)
Bangladesh (3)	Brazil (6)	Barbados (1)	Austria (2)
Bolivia (1)	Burundi (1)	Bulgaria (1)	Canada (8)
Cameroon (1)	Columbia (9)	Chile (6)	Cyprus (5)
Egypt (3)	Ecuador (5)	China (16)	Denmark (1)
Ghana (23)	Jamaica (39)	Costa Rica (1)	Finland (1)
Guyana (5)	Philippines (5)	Czech Republic (1)	France (10)
India (7)	South Africa (9)	Greece (1)	Germany (11)
Iran (1)	Thailand (2)	Hungary (2)	Holland (2)
Iraq (1)	Turkey (5)	Ireland (13)	Italy (6)
Ivory Coast (2)		Lithuania (2)	Japan (1)
Kenya (2)		Malaysia (1)	Singapore (1)
Malawi (2)		Mauritius (2)	Spain (10)
Morocco (1)		New Zealand (7)	Sweden (1)
Pakistan (7)		Poland (5)	Switzerland (1)
Saudi Arabia (1)		Portugal (12)	
Senegal (1)		Romania (3)	
Sierra Leone (12)		Russia (5)	
Uganda (2)		Slovakia (4)	
Zambia (1)		Taiwan (2)	
Zimbabwe (1)		Tunisia (1)	
		Ukraine (3)	
		United States (6)	
		Venezuela (1)	

The countries of origin for 67 migrant women in the SELCoH study are not included in the UN Gender Inequality Index as data were not available from these countries for the relevant dimensions (see Table 17). These women were not included in the GII analyses. Omission of scores for countries was not based on development level (e.g. when compared to the standard UN Human Development Index [408]), and thus the results are not biased due to this.

Table 17 Countries of origin omitted from the Inequality-adjusted Human Development Index (n=67)

Country of origin	Number of women in sample
Angola	3
Eritrea	5
Ethiopia	3
Grenada	2
Guinea Bissau	2
Hong Kong	2
Kosovo	1
Nigeria	46
Serbia	1
Somalia	1
Tanzania	1

4.2.3.2.2 Individual characteristics

For a description of socio-demographic, socio-economic, physical health, and social resource variables see chapter 3, page 91.

4.2.3.2.3 Stressful life events

For a description of potentially traumatic and 'other' childhood and lifetime stressful life events see chapter 3, page 91.

4.2.3.2.4 Outcome measures

The primary outcome in this study is high levels of psychological symptoms, including common mental disorders (measured using the CIS-R) and Post Traumatic Stress Disorder (measured using a PTSD screen). For a description of this variable see chapter 3, page 91.

4.2.3.3 Statistical analysis

Data analysis was conducted using Stata statistical software (Release 10) [356]. In the univariate analysis I examined the association of IHDI and GII levels with high levels of psychological symptoms. Logistic regression was used to identify unadjusted odds ratios with 95% confidence intervals and p-values. For the association of individual characteristics and stressful life events with psychological symptoms see chapter 3, Table 9 (page 117), Table 10 (page 120), and Table 11 (page 122). For the distribution of individual characteristics and exposure to stressful life events according to IHDI and GII level, see Appendix 5, page 399. In the multivariate analysis I used logistic regression to examine the relationship between psychological symptoms and 1) IHDI level and 2) GII level. I first adjusted for age and each potential confounder individually, and then adjusted for all covariates simultaneously.

4.2.4 Results

A total of 913 women were included in the analyses using the IHDI, including 360 (39.4%) first generation migrant women, and 553 (60.6%) women born in the UK. A total of 877 women were included in the analyses using the GII, including 324 (36.9%) first generation migrant women, and 553 (63.1%) women born in the UK.

4.2.4.1 Risk of psychological symptoms for migrant and non-migrant women according to IHDI and GII level

Women from medium IHDI level countries of origin were found to be significantly more likely to experience high levels of psychological symptoms compared with women born in the UK. GII level was not found to be associated with psychological symptoms. (See Table 18).

Table 18 Risk of psychological symptoms for migrant and non-migrant women by IHDI and GII level†

Variable	n	Prevalence of Outcome ††		Unadjusted OR [95% CI]	*p-value*
		n	%, [95% CI]		
Inequality-adjusted Human Development Index †††					
Born in the UK	553	164	28.6 [24.9 – 32.6]	1.0	---
Very low IHDI level	103	25	24.5 [16.5 – 34.8]	0.8 [0.5 – 1.4]	*0.44*
Low IHDI level	75	16	22.7 [14.2 – 34.4]	0.7 [0.4 – 1.4]	*0.32*
Medium IHDI level	91	40	46.9 [36.4 – 57.8]	2.2 [1.4 – 3.6]	*0.001***
High IHDI level	91	20	21.8 [14.4 – 31.5]	0.7 [0.4 – 1.2]	*0.18*
Gender Inequality Index					
Born in the UK	549	164	28.6 [24.9 – 32.6]	1.0	---
Very high GII level	79	22	26.7 [17.6 – 38.4]	1.0 [0.6 – 1.8]	*0.91*
High GII level	82	26	35.9 [25.6 – 47.7]	1.1 [0.6 – 1.8]	*0.81*
Medium GII level	90	27	29.9 [20.6 – 41.2]	1.4 [0.8 – 2.4]	*0.20*
Low GII level	71	20	29.3 [19.7 – 41.1]	0.9 [0.5 – 1.6]	*0.75*

† Data have been weighted to correct for non-response bias, and for clustering in the household survey. Analysis accounts for the survey design and the weighting. Sample sizes, medians, quartiles, and ranges are unweighted.
†† This included either meeting the cut off score of 12 in the CIS-R or screening positive on the PTSD screen.
* p<.05 ** p<.01 *** p<.001

4.2.4.2 Exploratory multivariate analysis of the effect of pre-migration macro-level factors on psychological symptoms

Women from medium IHDI level countries were found to be twice as likely as women born in the UK to experience high levels of psychological symptoms (see Table 19 and Table 20). GII level was not found to have a significant effect on psychological symptoms (Table 21 and Table 22).

Table 19 Association of IHDI level with psychological symptoms†

Variable (covariates) (born in the UK = reference)	**N**	**Odds Ratio**	**[95% CI]**	***p-value***
IHDI level	907			
Very low IHDI level		0.8	[0.5 – 1.4]	*0.44*
Low IHDI level		0.7	[0.4 – 1.4]	*0.32*
Medium IHDI level		2.2	[1.4 – 3.6]	*0.001***
High IHDI level		0.7	[0.4 – 1.2]	*0.18*
IHDI level adj for age	907			
Very low IHDI level		0.8	[0.5 – 1.4]	*0.41*
Low IHDI level		0.7	[0.4 – 1.4]	*0.32*
Medium IHDI level		2.2	[1.4 – 3.6]	*0.001***
High IHDI level		0.7	[0.4 – 1.2]	*0.17*
IHDI level adj for age + ethnicity	906			
Very low IHDI level		0.9	[0.4 – 2.1]	*0.86*
Low IHDI level		0.7	[0.3 – 1.4]	*0.27*
Medium IHDI level		2.1	[1.3 – 3.5]	*0.004***
High IHDI level		0.7	[0.4 – 1.2]	*0.17*
IHDI level adj for age + number of children	907			
Very low IHDI level		0.7	[0.4 – 1.3]	*0.27*
Low IHDI level		0.7	0.4 – 1.3]	*0.28*
Medium IHDI level		2.1	[1.3 – 3.4]	*0.004***
High IHDI level		0.7	[0.4 – 1.2]	*0.17*
IHDI level adj for age + relationship status	907			
Very low IHDI level		0.8	[0.5 – 1.3]	*0.34*
Low IHDI level		0.7	[0.4 – 1.3]	*0.29*
Medium IHDI level		2.2	[1.3 – 3.6]	*0.002***
High IHDI level		0.7	[0.4 – 1.2]	*0.19*
IHDI level adj for age + household monthly gross income category	776			
Very low IHDI level		0.8	[0.4 – 1.3]	*0.32*
Low IHDI level		0.7	[0.3 – 1.3]	*0.24*
Medium IHDI level		1.8	[1.0 – 3.0]	*0.04**
High IHDI level		0.7	[0.4 – 1.3]	*0.31*
IHDI level adj for age + employment status	903			
Very low IHDI level		0.8	[0.5 – 1.3]	*0.39*
Low IHDI level		0.7	[0.4 – 1.4]	*0.32*
Medium IHDI level		2.2	[1.4 – 3.6]	*0.001***
High IHDI level		0.7	[0.98– 0.99]	*0.20*
IHDI level adj for age + education level	895			
Very low IHDI level		0.7	[0.4 – 1.3]	*0.28*
Low IHDI level		0.7	[0.4 – 1.3]	*0.29*
Medium IHDI level		2.1	[1.3 – 3.4]	*0.003***
High IHDI level		0.8	[0.5 – 1.3]	*0.34*
IHDI level adj for age + long standing conditions	901			
Very low IHDI level		0.8	[0.5 – 1.3]	*0.37*
Low IHDI level		0.7	[0.4 – 1.4]	*0.35*
Medium IHDI level		2.3	[1.4 – 3.8]	*0.001***
High IHDI level		0.7	[0.4 – 1.2]	*0.21*
IHDI level adj for age + social support	897			
Very low IHDI level		0.7	[0.4 – 1.2]	*0.19*
Low IHDI level		0.7	[0.3 – 1.3]	*0.21*
Medium IHDI level		2.0	[1.3 – 3.3]	*0.004***
High IHDI level		0.7	[0.4 – 1.2]	*0.23*
IHDI level adj for age + social network	904			

size				
Very low IHDI level		0.7	[0.4 – 1.3]	*0.27*
Low IHDI level		0.6	[0.3 – 1.2]	*0.18*
Medium IHDI level		2.1	[1.3 – 3.5]	*0.003***
High IHDI level		0.7	[0.4 – 1.2]	*0.15*
IHDI level adj for age + potentially traumatic childhood stressful life events	897			
Very low IHDI level		0.8	[0.4 – 1.3]	*0.36*
Low IHDI level		0.7	[0.4 – 1.4]	*0.37*
Medium IHDI level		2.2	[1.3 – 3.6]	*0.002***
High IHDI level		0.6	[0.4 – 1.1]	*0.13*
IHDI level adj for age + other childhood stressful life events	901			
Very low IHDI level		0.7	[0.4 – 1.2]	*0.24*
Low IHDI level		0.7	[0.4 – 1.3]	*0.25*
Medium IHDI level		2.1	[1.3 – 3.4]	*0.003***
High IHDI level		0.7	[0.4 – 1.2]	*0.22*
IHDI level adj for age + potentially traumatic lifetime stressful life events	900			
Very low IHDI level		0.7	[0.4 – 1.3]	*0.27*
Low IHDI level		0.8	[0.4 – 1.5]	*0.48*
Medium IHDI level		2.2	[1.3 – 3.6]	*0.002***
High IHDI level		0.7	[0.4 – 1.3]	*0.26*
IHDI level adj for age + other lifetime stressful life events	892			
Very low IHDI level		0.7	[0.4 – 1.3]	*0.30*
Low IHDI level		0.6	[0.3 – 1.2]	*0.12*
Medium IHDI level		2.3	[1.4 – 3.7]	*0.001***
High IHDI level		0.7	[0.4 – 1.2]	*0.16*
IHDI level adj for all covariates	732			
Very low IHDI level		1.3	[0.4 – 4.8]	*0.64*
Low IHDI level		0.5	[0.2 – 1.2]	*0.13*
Medium IHDI level		2.1	[1.1 – 3.8]	*0.02**
High IHDI level		0.7	[0.4 – 1.3]	*0.26*

† Data have been weighted to correct for non-response bias, and for clustering in the household survey.
* p<.05 ** p<.01 *** p<.001

Table 20 Fully adjusted model for IHDI level: Risk factors for high levels of psychological symptoms (n=732) †

Variable (covariates)	Adjusted Odds Ratio	[95% CI]	*p-value*
IHDI level (born in UK = reference)			
Very low IHDI level	1.3	[0.4 – 4.8]	*0.64*
Low IHDI level	0.5	[0.2 – 1.2]	*0.13*
Medium IHDI level	2.1	[1.1 – 3.8]	*0.02**
High IHDI level	0.7	[0.4 – 1.3]	*0.26*
Age	1.0	[1.0 – 1.0]	*<0.001***
Ethnic Category (white = reference)			
Black Caribbean	0.5	[0.3 – 1.0]	*0.06*
Black African	0.4	[0.1 – 1.3]	*0.13*
Asian and Other	1.0	[0.5 – 1.7]	*0.90*
Relationship Status (single = reference)			
Married/cohabiting	0.9	[0.6 – 1.5]	*0.70*
Divorced/separated/widowed	1.6	[0.9 – 2.8]	*0.12*
Number of children	1.1	[0.9 – 1.2]	*0.35*
Household Monthly Gross Income Category (£0 - £420 = reference)			
£421 - £928	0.6	[0.3 – 1.2]	*0.18*
£929 - £1,592	1.1	[0.6 – 2.1]	*0.82*
£1,593 - £2,416	0.8	[0.3 – 1.6]	*0.47*
£2,417 or more	0.7	[0.4 – 1.3]	*0.24*
Employment (in paid employment = reference)			
Unemployed	0.9	[0.5 – 1.7]	*0.76*
Economically inactive	0.8	[0.5 – 1.4]	*0.43*
At home looking after children	0.7	[0.3 – 1.6]	*0.41*
Education level (no qualification = reference)			
GCSE or A-level or equivalent	0.8	[0.4 – 1.7]	*0.62*
Degree level or above	0.7	[0.3 – 1.4]	*0.27*
Long standing physical condition	1.8	[1.2 – 2.6]	*0.007***
Social support (low = reference)	0.4	[0.2 – 0.8]	*0.01**
Social network size	0.8	[0.7 – 0.9]	*<0.001****
Potentially traumatic childhood stressful life events	1.9	[1.3 – 2.8]	*0.002***
Other childhood stressful life events	1.1	[0.8 – 1.7]	*0.58*
Potentially traumatic lifetime stressful life events	2.0	[1.3 – 3.1]	*0.003***
Other lifetime stressful life events	1.8	[1.1 – 3.0]	*0.03**

† Data have been weighted to correct for non-response bias, and for clustering in the household survey.
* p<.05 ** p<.01 *** p<.001

Table 21 Association of GII level with psychological symptoms†

Variable (covariates) (born in the UK = reference)	n	Odds Ratio	[95% CI]	*p-value*
GII level	871			
Very High GII level		1.0	[0.6 – 1.8]	*0.91*
High GII level		1.1	[0.6 – 1.8]	*0.81*
Medium GII level		1.4	[0.8 – 2.4]	*0.20*
Low GII level		0.9	[0.5 – 1.6]	*0.75*
GII level adj for age	871			
Very High GII level		1.0	[0.6 – 1.8]	*0.95*
High GII level		1.0	[0.6 – 1.8]	*0.88*
Medium GII level		1.4	[0.8 – 2.4]	*0.19*
Low GII level		0.9	[0.5 – 1.6]	*0.76*
GII level adj for age + ethnicity	870			
Very High GII level		1.0	[0.6 – 1.8]	*0.94*
High GII level		1.1	[0.6 – 1.8]	*0.87*
Medium GII level		1.2	[0.7 – 2.2]	*0.46*
Low GII level		1.0	[0.5 – 2.0]	*1.00*
GII level adj for age + relationship status	871			
Very High GII level		1.1	[0.6 – 1.8]	*0.87*
High GII level		1.1	[0.6 – 1.9]	*0.75*
Medium GII level		1.3	[0.8 – 2.3]	*0.31*
Low GII level		0.9	[0.5 – 1.6]	*0.72*
GII level adj for age + number of children	871			
Very High GII level		1.0	[0.6 – 1.8]	*0.94*
High GII level		1.0	[0.6 – 1.8]	*0.91*
Medium GII level		1.3	[0.8 – 2.2]	*0.34*
Low GII level		0.8	[0.5 – 1.5]	*0.56*
GII level adj for age + household monthly gross income category	748			
Very High GII level		1.1	[0.6 – 1.9]	*0.76*
High GII level		1.1	[0.6 – 2.0]	*0.70*
Medium GII level		1.0	[0.5 – 1.8]	*0.95*
Low GII level		0.9	[0.5 – 1.6]	*0.60*
GII level adj for age + employment status	868			
Very High GII level		1.1	[0.6 – 1.9]	*0.88*
High GII level		1.1	[0.6 – 1.8]	*0.84*
Medium GII level		1.4	[0.8 – 2.4]	*0.22*
Low GII level		0.9	[0.5 – 1.6]	*0.73*
GII level adj for age + education level	859			
Very High GII level		1.1	[0.6 – 2.0]	*0.73*
High GII level		1.1	[0.6 – 1.9]	*0.76*
Medium GII level		1.3	[0.8 – 2.2]	*0.33*
Low GII level		0.9	[0.5 – 1.6]	*0.76*
GII level adj for age + long standing conditions	867			
Very High GII level		1.0	[0.6 – 1.8]	*0.98*
High GII level		1.1	[0.6 – 1.9]	*0.79*
Medium GII level		1.5	[0.9 – 2.5]	*0.14*
Low GII level		0.9	[0.5 – 1.6]	*0.63*
GII level adj for age + social support	862			
Very High GII level		1.1	[0.6 – 1.9]	*0.83*
High GII level		1.0	[0.6 – 1.8]	*0.88*
Medium GII level		1.3	[0.7 – 2.2]	*0.38*
Low GII level		0.8	[0.4 – 1.4]	*0.41*
GII level adj for age + social network size	869			
Very High GII level		1.0	[0.6 – 1.8]	*0.98*
High GII level		1.0	[0.6 – 1.7]	*0.98*
Medium GII level		1.4	[0.8 – 2.4]	*0.30*

Low GII level		0.8	[0.5 – 1.5]	*0.49*
GII level adj for age + potentially traumatic childhood stressful life events	861			
Very High GII level		1.0	[0.6 – 1.7]	*0.92*
High GII level		1.1	[0.6 – 1.8]	*0.85*
Medium GII level		1.4	[0.8 – 2.4]	*0.24*
Low GII level		0.9	[0.5 – 1.7]	*0.75*
GII level adj for age + other childhood stressful life events	866			
Very High GII level		1.1	[0.6 – 1.9]	*0.82*
High GII level		1.1	[0.6 – 1.8]	*0.85*
Medium GII level		1.3	[0.8 – 2.3]	*0.30*
Low GII level		0.8	[0.5 – 1.5]	*0.56*
GII level adj for age + potentially traumatic lifetime stressful life events	865			
Very High GII level		1.1	[0.6 – 2.0]	*0.74*
High GII level		1.1	[0.6 – 1.9]	*0.72*
Medium GII level		1.4	[0.8 – 2.4]	*0.28*
Low GII level		0.9	[0.5 – 1.7]	*0.78*
GII level adj for age + other lifetime stressful life events	858			
Very High GII level		1.0	[0.6 – 1.8]	*0.98*
High GII level		1.1	[0.6 – 1.8]	*0.82*
Medium GII level		1.3	[0.8 – 2.2]	*0.35*
Low GII level		0.9	[0.5 – 1.6]	*0.74*
GII level adj for all covariates	707			
Very High GII level		1.2	[0.5 – 2.9]	*0.76*
High GII level		0.8	[0.4 – 1.8]	*0.58*
Medium GII level		1.3	[0.7 – 2.3]	*0.47*
Low GII level		1.0	[0.6 – 2.0]	*0.90*

† Data have been weighted to correct for non-response bias, and for clustering in the household survey.
* p<.05 ** p<.01 *** p<.001

Table 22 Fully adjusted model for GII level: Risk factors for high levels of psychological symptoms (n=707) †

Variable (covariates)	Adjusted Odds Ratio	[95% CI]	*p-value*
GII level			
Very High GII level	1.2	[0.5 – 2.9]	*0.76*
High GII level	0.8	[0.4 – 1.8]	*0.58*
Medium GII level	1.3	[0.7 – 2.3]	*0.47*
Low GII level	1.0	[0.6 – 2.0]	*0.90*
Age	1.0	[1.0 – 1.0]	*<0.001***
Ethnic Category (white = reference)			
Black Caribbean	0.8	[0.4 – 1.6]	*0.46*
Black African	0.5	[0.2 – 1.2]	*0.13*
Asian and Other	0.8	[0.5 – 1.4]	*0.47*
Relationship Status (single = reference)			
Married/cohabiting	0.9	[0.5 – 1.4]	*0.55*
Divorced/separated/widowed	1.6	[0.9 – 2.8]	*0.13*
Number of children	1.1	[0.9 – 1.3]	*0.22*
Household Monthly Gross Income Category (£0 - £420 = reference)			
£421 - £928	0.6	[0.3 – 1.2]	*0.13*
£929 - £1,592	1.1	[0.6 – 2.2]	*0.79*
£1,593 - £2,416	0.7	[0.3 – 1.6]	*0.43*
£2,417 or more	0.7	[0.4 – 1.4]	*0.29*
Employment (in paid employment = reference)			
Unemployed	0.8	[0.4 – 1.5]	*0.47*
Economically inactive	0.8	[0.5 – 1.3]	*0.34*
At home looking after children	0.7	[0.3 – 1.5]	*0.40*
Education level (no qualification = reference)			
GCSE or A-level or equivalent	0.9	[0.4 – 1.7]	*0.68*
Degree level or above	0.6	[0.3 – 1.3]	*0.23*
Long standing physical condition	1.8	[1.2 – 2.8]	*0.004***
Social support (low = reference)	0.4	[0.2 – 1.0]	*0.04**
Social network size	0.8	[0.7 – 0.9]	*0.001***
Potentially traumatic childhood stressful life events	1.7	[1.2 – 2.5]	*0.008***
Other childhood stressful life events	1.2	[0.8 – 1.7]	*0.48*
Potentially traumatic lifetime stressful life events	2.1	[1.4 – 3.4]	*0.001***
Other lifetime stressful life events	1.9	[1.1 – 3.1]	*0.02**

† Data have been weighted to correct for non-response bias, and for clustering in the household survey.
* p<.05 ** p<.01 *** p<.001

4.2.5 Discussion

4.2.5.1 Main findings

Migrant women from medium IHDI level countries were significantly more likely than women born in the UK to experience high levels of psychological symptoms, but there was no difference in the risk of experiencing high levels of psychological symptoms between migrant women and women born in the UK based on the GII levels of women's countries of origin. These exploratory findings should be interpreted with caution, but suggest that macro-level factors (e.g. levels of educational attainment, health, standard of living, and inequalities), which may determine individual level

factors including access to education, employment, health services, basic resources, or the roles of women, may contribute to differences in risk among migrant women.

This finding supports previous research suggesting that macro-level factors may be associated with mental health outcomes for migrants [46, 51, 369, 397, 418]. Several studies have also pointed to similar trends to those identified in this study in the relationship between country of origin and risk of poor mental health (though the country-level indicators (e.g. region or GNP rather than IDHI) and outcome measures vary [6, 369, 394, 409-414, 416, 417]). Some studies have identified that migrants from specific medium IHDI level countries of origin (in South America, the Caribbean, and Eastern Europe) are at increased risk of poor mental health outcomes compared to other native or migrant populations [24, 51, 371, 397, 419-422]. Research has also shown that women from countries categorised her as medium IHDI level may be at increased risk compared to women from countries categorised as low or very low IHDI level [24, 369], or from high IHDI level (or 'Western') countries [27, 43, 423, 424]. While some studies have reported similar findings, it is unclear why women from medium IHDI level countries of origin may be at increased risk; there may be other factors that explain this relationship or contribute to differences in risk among migrant women.

As demonstrated in this study and the previous chapter, potentially traumatic childhood and lifetime stressful life events, and other lifetime events were found to significantly increase risk (See Table 20 and Table 22). However, these experiences did not explain the effect of IHDI level on psychological symptoms. Exposure to stressful life events may explain the findings of other studies, however. For example, in Lindert et al's meta-analysis, rates of depression were lowest for labour migrants from countries with a high gross national product, however being from a country with a high gross national product was not associated with decreased risk for refugees [43]. This may be due to exposure to stressful life events in this population. Reason for migration (e.g. forced migration) may also explain these findings; refugees have consistently been found to be at increased risk of psychological symptoms compared to labour migrants [46, 69, 371, 425]. The next analysis explores the relationship between reason for migration and psychological symptoms.

The transition to the UK (a high IHDI level country) and corresponding acculturation stressors may contribute to differences in risk identified in this study [48, 373]. For example, women from medium IHDI level countries may be more likely to experience status incongruence or downward mobility when migrating to high IHDI level countries than migrants from other IHDI level countries. This may include occupational downgrading or deskilling (a process where previous qualifications or training are not recognised, or jobs comparable to those in the country of origin are not available), a reduction in social class, or failed expectations which have been shown to increase the risk of experiencing high levels of psychological symptoms [90, 426-430]. Migrants from lower IHDI level countries may be more likely to experience improvement in socio-economic status or access to resources when moving to high IHDI level countries like the UK than women from medium IHDI level countries due to lower relative socio-economic status prior to migration, increased opportunities (for example in education, employment, or standard of living), and lower levels of inequalities in the UK compared to in their countries of origin. Migrants from high IHDI level countries may be more likely to retain status in these areas when migrating to the UK due to the transferability of qualifications between countries, individual socio-economic status prior to migration, or English proficiency.

Other acculturation stressors associated with psychological symptoms may also vary across groups, for example isolation due to 'othering' or rejection by the host community [130, 431, 432], or stigma, racism, discrimination, or class prejudice [29, 433-441]. These may be linked to gender, ethnicity, migrant status, language proficiency, or socio-economic status (which often intersect) [229, 230, 232, 442]. These experiences in the UK may be more prevalent or have a more detrimental impact for women from specific countries (for example the Caribbean [443] or Eastern Europe [444], medium IHDI level countries), than other groups. These factors can be explored further in qualitative studies (see chapters 5-7).

It was anticipated that women from lower IHDI level countries of origin would experience increased risk, as factors associated with lower levels of education, health, or standard of living, and higher levels of inequalities have been shown to be associated with poor mental health [334, 391-397, 400, 402-405]. Further insight into the effect of migration and IHDI level on psychological symptoms could be gained by investigating whether

migrants in the UK are at increased risk of experiencing high levels of psychological symptoms compared to individuals in their countries of origin.

There were no differences identified between migrant women and women born in the UK according to the GII level of women's countries of origin. This finding was unexpected as it was anticipated that migrant women from countries with higher levels of gender inequality would experience increased risk, as identified in previous research [6, 334, 392, 393, 400, 405, 413, 414]. It may be that gender inequality levels post-migration (in the UK) are more relevant to current mental health than levels of gender inequality in a migrant's country of origin prior to migration, explaining why no association was found. Furthermore, levels of gender inequality may predict differences in risk of psychological symptoms between men and women, though it was not found to be a significant predictor among migrant women and women born in the UK. As for IHDI level, further insight into the effect of migration and GII level on psychological symptoms could be gained by investigating differences in the risk of experiencing high levels of psychological symptoms between migrant women in the UK and women in their countries of origin.

4.2.5.2 Strengths and limitations

4.2.5.2.1 Strengths

This study included a diverse sample of migrant women and women born in the UK. The inclusion of women from a range of countries of origin enabled me to examine differences in risk between migrant women and women born in the UK based on the IHDI and GII levels of their countries of origin. The use of these specific measures represents another strength of the study. As discussed in section 4.1 (page 134), these measures include a range of social indicators shown to be associated with psychological symptoms including education, health status, living standards, health, empowerment, labour, and inequalities (including gender inequalities). These measures are also potentially more comprehensive and appropriate indicators than other measures, use data available for a wider range of countries than other similar measures used in previous research, and can be used independently.

4.2.5.2.2 Limitations

The limitations discussed in the previous chapter are also relevant to this analysis. A few additional limitations in this study should also be noted.

This study was exploratory, and consequently the finding that women from medium IHDI level countries are at increased risk compared to women born in the UK may be due to chance. Further research should be done to provide more insight into the relationship between macro-level factors (e.g. levels of health, education, living standards, and inequalities) and psychological symptoms for migrants.

The use of macro-level variables (e.g. GII or IHDI level) to explain individual psychological symptoms deserves reflection. These indicators were utilised as part of an ecological framework to reflect the context within which women were living prior to migration. It is important to recognise, however, that these variables are indicators of factors at a national level, and do not necessarily reflect the background of each individual. Furthermore, the circumstances of migrant women and levels of development may vary widely within the same category. Thus, the relationship between these macro-level factors and individual mental health may not be consistent.

There are important limitations to these indices that should also be noted. The mean number of years in the UK for migrant women in the sample is 18.4 [95% CI: 16.6 – 20.2]. However, the IHDI and GII scores are based on recent measurements (2008 or later) for the relevant dimensions. Countries may not have been of the same level at the time women migrated, and these indicators may not accurately reflect women's experiences while they were still living in their country of origin. As both of these indices are new (developed in 2010), it is not feasible to check if the scores for countries have varied greatly over time. However, there is no trend based on development level evident in the change in countries' rankings over time in the Human Development Index, which was developed in 1990 and includes similar dimensions to the IHDI. Furthermore, these changes in ranking lead to shifts in development category for only a very small number of countries [445].

The IHDI and GII have been criticised for their complexity (both in combining multiple indicators in one measure, and the calculation of the scores), which may make them difficult to interpret [410, 411, 446, 447]. Additionally, the measures may be biased towards higher development level countries (e.g. focusing on the formal economy, and not

representing the informal sector or women's reproductive roles; or using measures that may be affected by differences in practices or policies, social, political, or economic context, or only consistently utilised in higher development level countries). This can limit the relevance of these indicators, and may make them less meaningful for lower income countries [411]. These indicators were selected, however, because of their strengths compared to similar indicators (see 4.1).

It is important to note that the validity of other measures in this study, for example for psychological symptoms, may also not be equally valid across populations, and may be affected by linguistic and cultural differences, including perceptions of what constitutes 'illness', distinct explanatory models of illness, or differences in symptom expression [18, 271, 272, 448, 449] (also see chapter 1, page 11, and chapter 3, page 91). Furthermore, trends in these differences may be correlated with macro-level factors like IHDI or GII levels. Conceptualisations of illness will be further explored in the qualitative study (see chapters 5-7).

As discussed in the previous chapter, the generalisability of the findings should also be considered. For example, only women living in private residences were eligible to participate, and consequently some populations were not represented. Furthermore, if the distribution of these women varied by IHDI level, the findings may be biased.

4.2.5.3 Conclusions

This exploratory analysis identified that women migrating from medium IHDI level countries of origin may be at increased the risk of experiencing high levels of psychological symptoms compared to women born in the UK. However, this finding may be due to chance.

The mechanisms that might cause women from medium IHDI level countries of origin to be at increased risk are unclear. Other factors relevant to migration (e.g. individual level migration specific factors like reason for migration or acculturation) may contribute to morbidity among migrant women. The next analysis aims to explore the relationship between reason for migration, level of acculturation, and psychological symptoms to provide more insight into differences in risk among migrant women.

4.3 Analysis II: Individual level migration specific factors

The conflicting findings in the research regarding the effect of migration on psychological symptoms may be attributed to the heterogeneity of migrant populations. Individual level factors relevant to or occurring during migration may explain differences in risk among migrant women [19, 59]. For example, reason for migration and level of acculturation have been shown to be associated with psychological symptoms [18, 19, 29, 68, 131, 132, 373, 450-452].

Women who migrate for asylum or other political reasons have been shown to be at increased risk of experiencing high levels of psychological symptoms compared to other migrant populations (e.g. labour migrants) [18, 19, 24, 68, 69, 371, 425, 450], and associated experiences (including physical or sexual violence, exposure to conflict, loss of loved ones, or detention) may further increase women's risk [70, 71, 120, 450, 453-455]. However, few studies have examined the association of reason for migration with psychological symptoms, accounting for exposure to stressful life events. Further research is needed which examines the relationship between reason for migration and psychological symptoms, adjusting for exposure to stressful life events.

Increased acculturation, including longer time since migration, younger age at migration, and increased proficiency in the language of the destination country, may be inversely associated with psychological symptoms [132, 135, 136, 145, 373, 456, 457]. However, findings regarding the relationship between level of acculturation and psychological symptoms are not consistent, with some research suggesting increased acculturation is associated with an increased risk of psychological symptoms [75, 131, 142], or that the relationship is non-linear or not significant [40, 131, 146 147-150]. Furthermore, there may be gender differences in the effect of level of acculturation on psychological symptoms. For example, in their cross-sectional survey of 291 Greek Cypriot migrants in Camberwell (London), Mavreas et al identified a higher prevalence of mental disorder among women with lower levels of acculturation, while there was a higher prevalence of mental disorder among men with higher levels of acculturation [132]. Further insight is needed into the effect of level of acculturation on psychological symptoms for migrant women.

4.3.1 Objectives

The specific objectives of this analysis are to:

Use data from a cross-sectional survey (the SELCoH Study) to explore how individual level migration specific factors (including reason for migration and level of acculturation) contribute to differences in risk across migrant women living in South East London, accounting for exposure to stressful life events, socio-demographic and socio-economic characteristics, physical health, and social resources.

4.3.2 Hypothesis

As this is an exploratory analysis, there are no hypotheses being tested.

4.3.3 Methods

4.3.3.1 Study population

All women in the SELCoH Study who reported being born outside the UK (see chapter 3, section 3.3.1, page 94).

4.3.3.2 Covariates

4.3.3.2.1 Individual level migration specific factors

Reason for migration: Free text data from self-reported reasons for migration were categorised as migrating for: family or partner; a better life (including for education, work, or a better life); or asylum or other political reasons. There were several participants who reported more than one reason for migrating. Five participants reported migrating for asylum or other political reasons and for family or partner. These participants were all categorised as migrating for asylum or political reasons, as migrating for these reasons is associated with specific conditions or experiences leading to migration (e.g. forced migration) and arriving in the UK (asylum processes). Furthermore, this reason for migration has been shown to be associated with an increased risk of experiencing high levels of psychological symptoms [18, 68, 69, 425, 450, 454, 458]. Seven women reported they migrated for family or a partner as well as for a better life. Where this occurred, the reason for migration was categorised as migrating for family or a partner, as this suggested these women had social resources (e.g. social networks or social support) in the UK, which may be protective [199, 220, 267]. This also

guided the use of this reason for migration as the base category for this variable in the analysis.

Level of acculturation:

Years in the UK: Self-reported number of years a participant had been in the UK at the time of interview. (Self-reported years in the UK may not be precise as exact dates of entry into the UK were not recorded and participants may have estimated the time they had been in the UK.)

Age at arrival in the UK: The number of years a participant reported being in the UK (see description above) was subtracted from their age (for details on the variable for age, see chapter 3, section 3.3.2.1.1, page 95).

Years in the UK and age at arrival do not necessarily reflect the time since migration or age at migration of women from their country of origin, as the process of migration can last several years, and participants may have entered multiple countries prior to migrating to the UK.

4.3.3.2.2 Individual characteristics

For a description of socio-demographic, socio-economic, physical health, and social resource variables see chapter 3, section 3.3.2, page 95.

Age: A categorical variable was used to avoid collinearity with the continuous variables for time since arrival in the UK and age at arrival in the UK. Categories are based on quartiles and include: 16-29; 30-39; 40-54; and 55 years of age or older.

4.3.3.2.3 Stressful life events

For a description of potentially traumatic and 'other' childhood and lifetime stressful life events see chapter 3, section 3.3.2.4, page 97.

4.3.3.2.4 Outcome measures

The primary outcome was defined as high levels of psychological symptoms, including symptoms of common mental disorders (measured using the CIS-R) and Post Traumatic Stress Disorder (measured using a PTSD screen) (see chapter 3, section 3.3.2.5, page 98).

4.3.3.3 Statistical analysis

Data analysis was conducted using Stata statistical software (Release 10) [356]. Summary statistics for the migration specific factors were examined. I examined whether the variables time since arrival in the UK and age at arrival in the UK were normally distributed. Using logistic regression, I then examined differences in the distribution of individual characteristics and experiences of stressful life events among migrants with and without high levels of psychological symptoms. For the distribution of level of acculturation, individual characteristics, and exposure to stressful life events by reason for migration, see Appendix 6, page 410. I then examined the relationship between migration specific factors and high levels of psychological symptoms. Logistic regression was used to calculate unadjusted odds ratios with 95% confidence intervals and p-values. In the multivariate analysis I used logistic regression to examine the relationship between reason for migration and level of acculturation (years in the UK, age at arrival in the UK, and English as a first language) and psychological symptoms, adjusting for socio-demographic characteristics, socio-economic status, physical health, social resources, and exposure to stressful life events.

4.3.4 Results

4.3.4.1 Sample size

There were 391 women in the SELCoH study who reported being born outside the UK and were included in the study sample.

4.3.4.2 Normality

Years in the UK and age at arrival in the UK were not normally distributed. The association of these variables with psychological symptom did not qualitatively change following transformation, and the original variables were retained for analysis.

4.3.4.2.1 Characteristics of migrant women with and without high-levels of psychological symptoms

The characteristics of migrant women with and without high levels of psychological symptoms are presented in Table 23. Migrant women with high levels of psychological symptoms were significantly less likely than women without high levels of psychological symptoms to earn between £421 - £928, or £1,593 or more per month, to

be educated at GSCE level or above, or to have high levels of social support, and were more likely to be economically inactive or to have a long standing physical illness. Migrant women with high levels of psychological symptoms also had smaller social network sizes.

Table 23 Characteristics of migrants with and without high levels of psychological symptoms

Variable	Migrants without high levels of psychological symptoms		Migrants with high levels of psychological symptoms		Unadjusted OR [95% CI]	*p-value*
	N	% [95% CI]	n	% [95% CI]		
Socio-demographic characteristics						
Age (n=389)						
17-29	81	25.4 [20.6 – 30.8]	33	25.0 [17.8 – 34.0]	1.0	---
30-39	90	28.8 [23.8 – 34.5]	20	15.8 [10.1 – 23.7]	0.6 [0.3 – 1.1]	*0.08*
40-54	69	24.0 [19.3 – 29.4]	39	33.1 [25.0 – 42.4]	1.4 [0.8 – 2.5]	*0.25*
55+	38	21.8 [16.5 – 28.3]	19	16.1 [17.7 – 36.7]	1.2 [0.6 – 2.4]	*0.59*
Ethnic Category (n=389)						
White	108	37.7 [31.8 – 43.9]	46	41.4 [32.2 – 51.2]	1.0	---
Black Caribbean	26	10.6 [7.2 – 15.3]	19	19.2 [12.3 – 28.8]	1.7 [0.8 – 3.4]	*0.17*
Black African	77	27.4 [22.1 – 33.4]	26	22.4 [15.3 – 31.5]	0.7 [0.4 – 1.3]	*0.32*
Asian and Other	67	24.4 [19.4 – 30.2]	20	17.0 [11.3 – 24.9]	0.6 [0.3 – 1.2]	*0.14*
Relationship Status (n=389)						
Single	82	26.9 [21.9 – 32.6]	35	28.6 [20.5 – 38.3]	1.0	---
Married/cohabiting	141	50.1 [43.9 – 56.2]	49	42.6 [33.2 – 52.5]	0.8 [0.5 – 1.4]	*0.43*
Divorced/separated/widowed	55	23.1 [18.1 – 29.0]	27	28.9 [20.6 – 38.8]	1.2 [0.6 – 2.2]	*0.61*
Number of Children (n=389)	278		111		1.03 [0.9 – 1.2]	*0.62*
Mean (S.E.) [95%CI]		1.9 (0.1) [1.6 – 2.2]		2.0 (0.2) [1.6 – 2.4]		
Median (25^{th} and 75^{th} percentiles)		1 (0, 3)		2 (0, 3)		
(Range)		(0 – 14)		(0 – 9)		
Socio-economic status						
Household Monthly Gross Income Category (n=334)						
£0 - £420	20	8.7 [5.6 – 13.3]	20	22.3 [14.8 – 32.3]	1.0	---
£421 - £928	45	19.7 [15.0 – 25.6]	19	20.0 [13.1 – 29.3]	0.4 [0.2 – 0.9]	*0.03**
£929 - £1,592	43	19.6 [14.7 – 25.6]	22	23.8 [15.9 – 34.1]	0.5 [0.2 – 1.1]	*0.08*
£1,593 - £2,416	37	15.2 [11.0 – 20.5]	8	7.6 [3.8 – 14.4]	0.2 [0.1 – 0.5]	*0.001***
£2,417 or more	92	36.8 [30.8 – 43.3]	28	26.3 [18.5 – 36.0]	0.3 [0.1 – 0.6]	*0.001***
Employment Status (n=386)						
In paid employment	154	53.1 [47.0 – 59.1]	50	41.8 [32.3 – 51.8]	1.0	---
Unemployed	25	8.7 [5.8 – 12.9]	16	13.4 [8.2 – 21.2]	1.9 [0.9 – 4.1]	*0.08*
Economically inactive	60	25.8 [20.5 – 31.9]	33	36.3 [27.1 – 46.5]	1.8 [1.0 – 3.1]	*0.04**

At home looking after children	37	12.4 [9.1 – 16.8]	11	8.6 [4.8 – 15.1]	0.9 [0.4 – 1.9]	*0.74*
Education level (n=382)						
No qualification	29	13.2 [9.3 – 18.5]	21	25.0 [16.9 – 35.3]	1.0	---
GCSE or A-level or equivalent	129	47.5 [41.4 – 53.6]	50	44.7 [35.3 – 54.4]	0.5 [0.3 – 1.0]	*0.04**
Degree level or above	116	39.3 [33.6 – 45.4]	37	30.3 [22.3 – 39.8]	0.4 [0.2 – 0.8]	*0.01**
Physical health						
Long standing condition (n=385)						
No	193	65.5 [59.2 – 71.2]	48	39.3 [30.3 – 49.0]	1.0	---
Yes	84	34.5 [28.8 – 40.8]	60	60.7 [51.0 – 69.7]	2.9 [1.8 – 4.7]	*<0.001***
Social resources						
Social support (n=383)						
Low Support	22	7.6 [5.0 – 11.4]	18	17.7 [11.3 – 26.5]	1.0	---
High Support	255	92.4 [88.6 – 95.0]	88	82.3 [73.5 – 88.7]	0.4 [0.2 – 0.8]	*0.006***
Social network size (n=386)	278		108		0.9 [0.8 – 1.0]	*0.03**
Mean (S.E.) [95%CI]		5.0 (0.1) [4.8 – 5.2]		4.5 (0.2) [4.2 – 4.9]		
Median (25^{th} and 75^{th} percentiles)		5 (4, 6)				
(Range)		(0 – 10)				

† Data have been weighted to correct for non-response bias, and for clustering in the household survey. Analysis accounts for the survey design and the weighting. Sample sizes, medians, quartiles, and ranges are unweighted.

* p<.05 ** p<.01 *** p<.001

4.3.4.2.2 Experiences of stressful life events among migrant women with and without high levels of psychological symptoms

Migrant women who had experienced potentially traumatic childhood stressful life events or any lifetime stressful life event were at increased risk of experiencing high levels of psychological symptoms (see Table 24).

Table 24 Experiences of stressful life events among migrant women with and without high levels of psychological symptoms

Variable	Migrants without high levels of psychological symptoms		Migrants with high levels of psychological symptoms		Unadjusted OR [95% CI]	*p-value*
	n	**%, [95% CI]**	**n**	**%, [95% CI]**		
Potentially traumatic childhood stressful life events (n=385)						
Not experienced	195	69.8 [63.9 – 75.2]	45	42.9 [33.8 – 52.5]	1.0	---
Experienced	82	30.2 [24.9 – 36.1]	*63*	57.1 [47.5 – 66.2]	3.1 [1.9 – 4.9]	*<0.001****
Other childhood stressful life events (n=386)						
Not experienced	157	56.6 [50.5 – 62.5]	54	49.3 [39.6 – 59.1]	1.0	---
Experienced	120	43.4 [37.5 – 49.5]	55	50.7 [40.9 – 60.5]	1.3 [0.8 – 2.1]	*0.22*
Potentially traumatic lifetime stressful life events (n=349)						
Not experienced	106	39.3 [33.4 – 45.5]	*20*	18.9 [12.3 – 27.9]	1.0	---
Experienced	172	60.7 [54.5 – 66.6]	*87*	81.1 [72.2 – 87.7]	2.8 [1.6 – 4.9]	*<0.001****
Other lifetime stressful life events (n=381)						
Not experienced	74	25.5 [20.6 – 31.1]	14	11.4 [6.6 – 19.0]	1.0	---
Experienced	199	74.5 [68.9 – 79.4]	94	88.6 [81.0 – 94.3]	2.7 [1.4 – 5.2]	*0.004***

† Data have been weighted to correct for non-response bias, and for clustering in the household survey. Analysis accounts for the survey design and the weighting. Sample sizes, medians, quartiles, and ranges are unweighted.

* p<.05 ** p<.01 *** p<.001

4.3.4.2.3 Migration specific risk factors for psychological symptoms among migrant women

Women migrating for asylum or other political reasons were found to be significantly more likely to experience high levels of psychological symptoms compared with women migrating for family or a partner. Women who had been in the UK for longer were also at increased risk (see Table 25).

Table 25 Migration specific risk factors for psychological symptoms†

Variable	n	Prevalence of psychological symptoms††		Unadjusted OR [95% CI]	*p-value*
		N	%, [95% CI]		
Reason for migration					
Family or Partner	165	42	25.6 [19.1 – 33.2]		---
A better life	180	50	29.1 [22.4 – 36.9]	1.2 [0.7 – 2.0]	*0.49*
Asylum or other political reasons	28	14	51.0 [32.7 – 69.1]	3.0 [1.3 – 7.1]	*0.01**
Years in the UK	386	111		1.02 [1.00 – 1.03]	*0.05**
Mean (S.E.) [95%CI]			21.3 (1.8) [17.6 – 24.9]		
Median (25^{th} and 75^{th} percentiles)			13 (7, 28)		
(Range)			(0 – 59)		
Age at arrival in the UK	388	111		0.99 [0.97 – 1.01]	*0.396*
Mean (S.E.) [95%CI]			23.3 (1.0) [21.4 – 25.2]		
Median (25^{th} and 75^{th} percentiles)			22 (17, 29)		
(Range)			(0 – 48)		
English as a first language					
Yes	173	61	27.3 [21.5 – 34.0]	1.0	---
No	117	53	31.32 [24.50 – 39.05]	1.21 [0.76 – 1.93]	*0.412*

† Data have been weighted to correct for non-response bias, and for clustering in the household survey. Analysis accounts for the survey design and the weighting. Sample sizes, medians, quartiles, and ranges are unadjusted.

†† This included either meeting the cut off score of 12 in the CIS-R or screening positive on the PTSD screen.

* p<.05 ** p<.01 *** p<.001

4.3.4.3 Exploratory multivariate analysis of the effect of individual level migration specific factors on psychological symptoms

After adjusting for all covariates, women who migrated for asylum or other political reasons were found to be at increased risk of experiencing high levels of psychological symptoms compared to women who migrated for family or a partner. None of the indicators of level of acculturation were found to have a significant effect on psychological symptoms for migrant women. Women with a household monthly gross income of between £1,593 and £2,416 were suggested to be at decreased risk of experiencing high levels of psychological symptoms (AOR: 0.3 [95% CI: 0.1 – 1.0], as were women with an educational level of GCSE or above. Social support was found to be protective (AOR: 0.2 [95% CI: 0.1 – 0.7]). Experiencing potentially traumatic childhood stressful life events was also found to be associated with an increased risk of experiencing high levels of psychological symptoms (AOR: 2.0 [95% CI: 1.1 – 3.9]) (see Table 26).

Table 26 Fully adjusted model: Migration specific risk factors for psychological symptoms (n=238)†

Variable (covariates)	Adjusted Odds Ratio	[95% CI]	*p-value*
Reason for migration (Family or partner = reference)			
A better life	1.5	[0.7 – 3.0]	*0.29*
Asylum or other political reasons	4.8	[1.1 – 20.6]	*0.04**
Years in the UK	1.0	[0.9 – 1.1]	*0.89*
Age at arrival in the UK	1.0	[0.9 – 1.1]	*0.90*
English as a first language (yes = reference)	1.0	[0.5 – 2.1]	*0.89*
Age (16 – 29 = reference)			
30-39	0.6	[0.2 – 1.7]	*0.33*
40-54	1.6	[0.3 – 8.5]	*0.55*
55+	0.4	[0.0 – 5.4]	*0.49*
Ethnic Category (white = reference)			
Black Caribbean	0.7	[0.2 – 2.7]	*0.64*
Black African	0.5	[0.2 – 1.3]	*0.16*
Asian and Other	0.5	[0.2 – 1.2]	*0.10*
Relationship Status (single = reference)			
Married/cohabiting	1.0	[0.5 – 2.1]	*0.98*
Divorced/separated/widowed	0.9	[0.4 – 2.2]	*0.81*
Number of children	0.8	[0.6 – 1.1]	*0.13*
Household Monthly Gross Income Category (£0 - £420 = reference)			
£421 - £928	0.5	[0.2 – 1.5]	*0.22*
£929 - £1,592	0.4	[0.2 – 1.1]	*0.09*
£1,593 - £2,416	0.3	[0.1 – 1.0]	*0.04**
£2,417 or more	0.4	[0.1 – 1.0]	*0.06*
Employment (in paid employment = reference)			
Unemployed	0.5	[0.2 – 1.5]	*0.22*

Economically inactive	1.3	[0.6 – 3.1]	*0.52*
At home looking after children	0.8	[0.2 – 3.4]	*0.80*
Education level (no qualification = reference)			
GCSE or A-level or equivalent	0.3	[0.1 – 0.8]	*0.02**
Degree level or above	0.2	[0.1 – 0.8]	*0.02**
Long standing physical condition	1.9	[1.0 – 3.7]	*0.07*
Social support (low = reference)	0.2	[0.1 – 0.7]	*0.008***
Social network size	0.9	[0.8 – 1.1]	*0.58*
Potentially traumatic childhood stressful life events	2.0	[1.1 – 3.9]	*0.03**
Other childhood stressful life events	1.1	[0.6 – 2.0]	*0.73*
Potentially traumatic lifetime stressful life events	1.7	[0.9 – 3.6]	*0.13*
Other lifetime stressful life events	1.9	[0.8 – 4.5]	*0.13*

† Data have been weighted to correct for non-response bias, and for clustering in the household survey.
* p<.05 ** p<.01 *** p<.001

4.3.5 Discussion

This exploratory analysis suggests that women who migrate for asylum or other political reasons are at increased risk of experiencing high levels of psychological symptoms compared to women who migrate for family or a partner (AOR: 4.8 [95% CI: 1.1 – 20.6]), after adjusting for individual characteristics, exposure to stressful life events, and social resources. This supports previous literature demonstrating asylum seekers and refugees are at increased risk compared to other migrants (e.g. labour migrants) [18, 68, 69, 425, 450, 454, 458]. The experience of forced migration may have contributed to this finding. However, I was unable to identify whether other women in the sample (e.g. those who had migrated for family or a partner) had limited agency in their migration, and consequently was unable to examine the relationship between experiences of forced migration and psychological symptoms.

Indicators of level of acculturation were not found to be associated with psychological symptoms after adjusting for individual characteristics and exposure to stressful life events. Research findings in this area have been inconsistent, with some research suggesting that acculturation is inversely associated with psychological symptoms [72, 76, 95, 131, 134, 135, 140, 141, 459], while other studies have reported that increased acculturation is positively associated with psychological symptoms [75, 131, 142], or that the relationship is not linear or is not significant [40, 131, 146 147-150]. The inconsistency in findings across studies may be attributed to variations in measures of level of acculturation, differing study populations, and the selection of other factors (e.g. stressful life events) accounted for in the analyses.

4.3.5.1 Strengths and limitations

4.3.5.1.1 Strengths

This study includes a diverse population of women, including women from diverse linguistic backgrounds. Much research excludes non-English speaking participants, which limits the representativeness of the sample, particularly in research with migrant populations. It is particularly relevant for research with asylum seeking or refugee populations. As identified in this chapter (see Appendix 6, page 410), women who migrate for asylum or other political reasons are significantly more likely not to speak

English as a first language; enabling women with limited English proficiency to participate in the study facilitated the inclusion of these populations. Another strength of this study is that it is distinct from some research exploring the relationship between reason for migration and psychological symptoms because it adjusted for the effects of exposure to stressful life events. Though certain migrant populations (e.g. asylum seekers and refugees) have been shown to be at increased risk of exposure to stressful life events [30], previous research (e.g. [69, 425]) has in some cases neglected or been unable to adjust for these factors when comparing morbidity between asylum seekers or refugees and other migrants.

4.3.5.1.2 Limitations

The limitations discussed in chapter 3, section 3.5.2.2 (page 129) are also relevant to this study. There were limitations to the data including potential differences in the interpretation of survey questions (e.g. due to language or cultural background) and barriers to reporting (e.g. reporting 'official' data may be particularly salient for migrants without leave to remain). There were also limitations relating to recruitment including barriers to recruiting women (e.g. due to household factors or migrant status). In addition, the survey is only representative of the population living in South East London, and may not be representative of mobile populations or those not living in private accommodation (e.g. detainees).

A few additional limitations to this study should also be noted. First, the sample size included in this analysis is significantly smaller than in the previous analyses, as the analysis only includes migrant women. Because of this, there were few women in some categories (e.g. women who migrated for asylum or other political reasons). My findings should therefore be interpreted with caution given the small number of migrant women included in the sample who migrated for this reason, and the consequent wide confidence intervals.

There are several factors which were not examined in this study, including experiences of stigma or discrimination, changes in socio-economic status or roles, failed expectations, and culture conflict, which have been shown to be associated with psychological symptoms for migrants [76, 90, 147, 260, 425, 429, 438, 440, 441, 460-462]. These factors may vary across migrant groups (e.g. due to reason for migration), and may contribute

to the findings in this study. This study was also not able to explore differences in the risk of psychological symptoms between asylum seekers and refugees, as current legal status was not identified. There may be important differences in these populations due to more secure status among refugees, whilst asylum seekers are awaiting a decision on their asylum claim. Insecure legal status has been shown to increase the risk of high levels of psychological symptoms [89, 96, 113, 114, 450]. Other protective factors in addition to social support or social network size, including access to coping resources or coping strategies, were also not examined here and may also vary across migrant groups. These factors will be explored further in chapters 6 and 7.

4.3.5.2 Conclusions

In this exploratory analysis, women who migrated for asylum or other political reasons were found to be at increased risk of experiencing high levels of psychological symptoms compared to women who migrated for family or a partner. No associations were identified between indicators of level of acculturation and psychological symptoms. The findings suggest that the context of migration, as well as exposure to stressful life events and social resources, may inform migrant women's mental health, and should be acknowledged when addressing their health needs.

While the findings suggest women who migrate for asylum or other political reasons may be at increased risk, these groups should not be assumed to be homogenous, or necessarily more 'vulnerable' to experiencing high levels of psychological symptoms, as this can result in the medicalisation, and potentially the marginalisation of these communities [63, 269, 271, 272, 463]. However, raising awareness of potentially 'high risk populations' may have advantages in terms of realising policy or health services focused on these migrants, developing appropriate care models, or facilitating their asylum claims [63, 272, 464].

Thus, the results reported in chapters 3 and 4 suggest that migrant women may not experience increased risk of experiencing high levels of psychological symptoms overall compared to women born in the UK, but that differences in risk may exist within the migrant population due to macro and individual level factors occurring at different stages of migration. Further research is needed to better understand factors impacting on the mental health and well-being of migrant women and women born in the UK. In

chapters 5-7, I aim to provide further insight into these factors using qualitative methods to investigate what factors migrant women and women born in the UK perceive to be significant in affecting their mental health and well-being, and how they are affected.

Chapter 5: Qualitative study of the mental health and well-being of migrant women and women born in the UK: Methodology

5.1 Introduction

In chapter 3 it was identified that migrant women were not at significantly increased risk of experiencing high levels of psychological symptoms compared with women born in the UK, but that stressful life events and long standing physical conditions, which were highly prevalent among migrant women and women born in the UK, were associated with increased risk. Chapter 4 suggested that the risk of experiencing high levels of psychological symptoms may vary across migrant populations.

In chapters 5-7, I describe a study which aims to explore what experiences women perceive have affected their mental health and well-being, how they have been affected, and how this differs for migrant women and women born in the UK through in-depth qualitative interviews. The use of qualitative methods allows for an in-depth exploration of the lived experience of migrant women and women born in the UK, and has the capacity to give insight into the context within which women's experiences are situated, and how women are affected by them [278, 465].

Most previous research focuses on specific migrant groups (e.g. refugees, migrants from specific countries of origin, etc.) [64, 466, 467], stressful life events (e.g. sexual or domestic violence) [157, 167, 246, 343, 453, 468-471], or outcomes (e.g. depression) [472-474]. While research focused on specific factors has important applications (e.g. identifying culturally specific illness models), it is limited in its ability to investigate broader processes, or variations across diverse communities of migrant women or between migrant and non-migrant women. Furthermore, such focused research is often limited in the extent to which participants are able to direct what is meaningful and consequently investigated in the research (e.g. experiences or outcomes) [326].

I therefore aimed to carry out a qualitative study which could compare the perspectives of a diverse sample of migrant women and women born in the UK living in London regarding what experiences they perceive have impacted on their mental health and well-being, and how they have been affected.

5.2 Aims

The study aims to investigate: 1) what experiences women in diverse communities in London perceive have affected their mental health and well-being; 2) how women's mental health and well-being have been affected by these experiences; and 3) how these experiences and women's conceptualisations of mental health and well-being differ for migrant women and women born in the UK.

5.3 Methods

5.3.1 Study design

Qualitative study with semi-structured in-depth individual interviews.

5.3.2 Study Population

Migrant women and women born in the UK living in London.

5.3.2.1 Inclusion and Exclusion Criteria

Inclusion criteria: Women aged 16 or older living in London, including: 1) women born in the UK, and 2) migrant women who migrated to the UK after the age of 16 (I chose to only include women who migrated after the age of 16 as they would have spent a substantial number of years in their countries of origin, have been more likely to understand the circumstances they were in when migrating, and would potentially have more distinct memories of their countries of origin and their experiences of migrating). Women were included regardless of English proficiency.

Exclusion criteria: Women deemed not to have capacity to consent (guided by the recommendations made in the 2005 Mental Capacity Act Framework [475, 476]); women who may be put at risk by participating (e.g. due to the sensitivity of the topics discussed, or their current mental health status); women whose participation could present a risk to myself (e.g. unsafe interview setting) (also see section 5.3.3.2, page 173, and Appendix 6:page 410); women who migrated to the UK before the age of 16.

5.3.3 Procedures

5.3.3.1 Ethical approval

This study was given ethical approval by the Psychiatry, Nursing and Midwifery Research Ethics Subcommittee, King's College London (ref PNM/09/10-109) (See Appendix 7, page 410).

5.3.3.2 Sampling strategy

Purposive sampling was used to recruit migrant women and women born in the UK from the South East London Community Health (SELCoH) study, where they had consented to be re-contacted for future studies (See chapter 3, section 3.2, page 92 for further information on participants in the SELCoH Study). Women were also recruited using purposive sampling from community organisations in London.

5.3.3.2.1 Community organisations

In order to represent a diverse sample of migrant women and women born in the UK in contact with community organisations, I aimed to recruit from women's shelters or resource centres (including organisations focused on specific needs, e.g. domestic violence, mental health, etc), migrant and refugee organisations, and organisations working with specific cultural or ethnic groups. Community organisations were identified through internet searches, local literature (including newspapers, magazines, and flyers), professionals working with communities of women, and subsequently from organisations with which I was in contact.

Guided by the characteristics of women living in London reported in the 2001 UK census [175], I utilised purposive sampling in order to recruit a diverse sample of migrant women and women born in the UK from these organisations with regards to age and ethnicity. In the migrant sample, I also sought to represent women with diverse experiences of migration (though some groups of migrants, for example trafficked populations, may represent a very small percentage of the migrants in the UK and have atypical experiences). I aimed to include migrant women representing a range of reasons for migration (e.g. forced migration (including for asylum or other political reasons, or trafficking), for a better life (e.g. for work or education), or for family or a partner)), regions of origin (e.g. Europe, Asia, South/Central America, Africa, Caribbean), and varying lengths of time in the UK (e.g. 0-5 years, 6-10 years, 11-19 years, or 20 or more years).

5.3.3.2.2 SELCoH Study

A total of 93.6% of women who participated in the SELCoH study consented to be re-contacted regarding future studies. A batch of 45 of these women was selected from the cross-sectional survey, from which I aimed to recruit approximately 15 women, including five women born in the UK and 10 migrant women. These 45 women were randomly selected from the participants in the SELCoH study using purposive sampling (guided by the characteristics of women living in London reported in the 2001 UK census [175]). A sampling frame was used to select women from the SELCoH sample based on age, parity, ethnicity, level of education, employment status, region of origin (according to self-reported country of origin), and time since arrival in the UK. Data on these characteristics was available from the cross-sectional data.

5.3.3.3 Recruitment

When invited to participate, all potential participants were provided a cover letter and information sheet outlining the purpose of the study, any risks involved, what participation would entail, and the confidentiality and anonymity of their participation (for all recruitment literature see Appendix 8, page 414). In order to ensure that they had the opportunity to fully understand the aims and requirements of the study prior to electing to participate, an effort was made to provide the study information sheet to potential participants a minimum of 48 hours prior to the interview. Women were also asked in what language they would prefer the study literature to be presented, as well as in what language they would like to conduct the interview. Where necessary, study literature was translated by a professional translation service, and checked by an independent interpreter to ensure accuracy and acceptability.

The information sheet and consent form were also provided at the interview prior to gaining women's consent. The information sheet and consent form were also thoroughly verbally explained, which was particularly essential in instances where women had limited literacy. Women were given the opportunity to ask questions regarding the study or their involvement prior to consenting to participate to ensure they fully understood the study. I also emphasised prior to acquiring women's consent that they should only participate if they wanted to and that choosing not to take part would not disadvantage them in any way. Where preferred by the participant, a professional

credentialed interpreter was present to explain the study, answer questions, gain consent, and conduct the interview.

I judged capacity to consent guided by the recommendations made in the 2005 Mental Capacity Act Framework [475, 476]. While participants recruited through the SELCoH study had their capacity to consent assessed when they participated in the SELCoH Study, capacity changes over time and an assessment is therefore needed each time consent is requested. I also discussed capacity to consent with gatekeepers (my contacts at community organisations) when enquiring if they would allow me to recruit from their organisations, and encouraged them to be aware of mental or physical health problems that might limit a woman's capacity to consent or ability to participate in the study, or the potential for the study to cause harm or distress, when inviting women to participate.

5.3.3.3.1 Recruitment from community organisations

When contacting community organisations in London to enquire if they would allow me to recruit women in contact with them, I provided a cover letter and information sheet about the study (provided in Appendix 8, sections 7.2 and 7.4, pages 415and 418).

When organisations agreed to participate, they were provided with posters, cover letters, and information sheets about the study. Study information was posted in communal areas and distributed to potential participants by gatekeepers. This enabled gatekeepers to invite women that might have been difficult to reach, or who might not have considered participating without the encouragement of a trusted contact [477]. I also recruited participants by visiting participating organisations and discussing the study with women in person.

Women interested in participating were able to notify gatekeepers who could provide further information or contact me on their behalf. My contact information was also included in all study literature, and women were able to contact me directly to express interest in participating or to gain more information (without having to notify gatekeepers). This enabled them to confidentially elect (or decline) to participate.

I aimed to speak directly with all participants about the study prior to making arrangements for an interview. This was done to emphasise the voluntary nature of this

research, to provide the opportunity for the participant to decline to participate (without having to do so through a gatekeeper) to prevent women from feeling pressure from gatekeepers to participate, and also to protect the confidentiality of their participation (or decision not to participate). Where this was not possible (e.g. where women had no access to phones or internet, or did not speak English) these communications were conducted via gatekeepers. For women referred to me via a gatekeeper, I emphasised to the gatekeeper that it was essential that potential participants had been provided all of the study information (in the language of their choice), and that it was essential they did not pressure women to participate. Prior to gaining women's consent, I also verbally explained that they were not obligated to participate and that they should not feel pressured to do so.

5.3.3.3.2 Recruitment from the SELCoH study

Women from the selected batches were organised into groups of five. This enabled me to contact and interview women in a timely manner, in line with the SELCoH study protocol [345], and to update the sampling criteria based on the characteristics of the successfully recruited sample. One batch of five participants was contacted at a time. For each batch, participants were approached and informed of the study through cover letters and information sheets mailed to the private addresses the SELCoH study had on record. One week after the letters were mailed, each woman in the batch was contacted by: 1) phone; calls were made at different times of day in an effort to reach the participant when they might be available; 2) e-mail (including the cover letter and information sheet), where contact could not be made by phone, and e-mail addresses were available; 3) house visits; visits were made at different times of day in an attempt to reach the participant when she was at home.

A maximum of six attempts were made to contact potential participants. If a woman was successfully contacted but declined to participate, she was not re-contacted. If an individual did express an interest in participating, an interview was scheduled and a location determined (see 5.3.3.4). An effort was made to conduct all interviews within two weeks of making successful contact with a woman. After every member of a batch was either interviewed, could not be contacted, or declined to participate, the next batch of invitations for participation was sent out. Batches were contacted until the desired

sample had been achieved, and a total of 34 women in seven batches (one of which only had four women) were invited to participate.

5.3.3.4 Interviews

I conducted all interviews. The average length of the semi-structured in-depth interviews was 1 hour and 4 minutes (range: 31 minutes - 1 hour and 50 minutes). Interviews were conducted in a private location chosen by the participant, including the organisation from which they were recruited or the King's College London Weston Education Centre. Women recruited from the SELCoH study were also able to elect to conduct interviews in their homes if their residences had been assessed to be safe by the SELCOH study team. However, I was aware that this assessment did not ensure safety at the point at which I was conducting interviews, as considerable time could have elapsed since the original SELCOH interview. In the event that I did not feel safe in an interview setting I could postpone the interview or make arrangements to conduct the interview elsewhere. I also had a safety protocol in place, including leaving details of where I was interviewing and checking in regularly with a member of the Section of Women's Mental Health when I was interviewing (see safety protocol, ethics application, Appendix 7, page 410).

Interviews were audio-recorded. One of the migrant women who participated in the study declined to be audio-recorded, however, and consequently the transcript of her interview could not be analysed. This interview was conducted with a professional credentialed female interpreter from the woman's country of origin. A second interview also required translation, and was conducted in Spanish. The woman had initially indicated she would like to do the interview in English and she had stated she spoke sufficient English to understand the literature provided, which had not been translated. However, at the time of the interview she suggested she would be more comfortable being interviewed in Spanish. I felt it was important to conduct the interview in the participant's preferred language, and opted to conduct the interview in Spanish myself. While it is recommended that professional credentialed interpreters are used, I have a bachelor's degree in Spanish, and felt that it would be more pragmatic to conduct the interview at that time as the participant was available and had consented. Furthermore, there are limitations to working with an interpreter, and benefits to having an

experienced researcher familiar with qualitative methods and the topic being examined conducting the interview (see chapter 2, page 50). Prior to gaining her consent, I also verbally translated the information sheet and consent form and discussed them in detail with the participant in Spanish.

At the end of interviews I asked women how they were feeling and if there was anything they wanted to discuss further (outside of the formal recorded interview). I also provided information about support resources (translated where relevant), which women could take with them if it was safe to do so, and I asked them if there was any other information (e.g. about specific services etc) that I could provide or acquire for them. I also ensured they had my contact information (e-mail address and office phone number) so they could contact me if needed.

Following interviews, participants were given £10 to thank them for their time and contribution to the study.

5.3.3.4.1 Topic guide

The topic guide was informed by the review conducted in chapter 1, as well as methodological guidance in the literature on conducting research on sensitive topics, feminist research methods, and with populations from diverse cultural or linguistic backgrounds. The topic guide was developed through consultation with experts in the field (e.g. psychiatrists, professionals working with women, community organisations, and women from the communities I was interviewing. I aimed to design the topic guide to prompt women to identify significant life experiences they perceived had an impact on their mental health and well-being, and for each experience, how they perceived it affected them or made them feel. It also included specific prompts on exposure to any forms of abuse or violence, and changes in their mental health or well-being. At the end of the topic guide I included a question asking if there were any other topics the participant felt were significant or relevant they would like to discuss that had not been covered in the interview (this also informed the development of the topic guide during piloting, see section 5.3.3.4.1.1, page 179). (See Appendix 8, page 425 for the topic guide).

The topic guide was structured using a narrative or life-course approach (sometimes also referred to as a biographical or chronological approach), beginning in childhood and proceeding chronologically, to enable women to identify significant experiences and changes in mental health and well-being in the order and temporal context in which they were experienced [478]. In the interviews with migrant women, the stages of migration were also discussed as part of the narrative, including: life in their country of origin, transit (the period between leaving their home country and arriving in the UK), and the period between arriving in the UK and the present. This enabled me to explore women's experiences during these phases of migration, which contributed to existing research on migrant populations which has frequently failed to explore factors occurring at each stage of migration that may impact on women's mental health or well-being, instead focusing on a specific period of migration or factors relevant at the point at which the study is conducted [31].

Though the topic guide was focused on the effect of migration and stressful life events on women's mental health and well-being, I hoped the open and flexible structure of the topic guide would enable participants to direct the interview in relation to the topics that they perceived to be significant, rather than the interview being dictated by my preconceptions. I also wanted to enable women to engage in the interview in their own terms (language, idioms, or concepts), which structured questionnaires cannot always accommodate [326, 479, 480]. I chose not to translate the topic guide, given the semi-structured format of the interviews, and instead discussed the oral translation of the topic guide with the interpreter prior to the cross-language interview to standardise their interpretation (see section 5.3.3.4.2, page 180).

5.3.3.4.1.1 Piloting

I first tested and subsequently discussed the interview guide with two researchers in my university department, and with three migrant women who did not speak English as a first language (a gatekeeper at one of the community organisations, and two students at the Institute of Psychiatry). During the first five interviews of the study, in addition to asking women if there were any other topics they would like to discuss that were not included in the interview guide, I asked participants if they had any feedback on the topics discussed, the terminology used (e.g. for cross-cultural or cross-language

purposes), and the appropriateness of how the topics were approached. These interviews were then transcribed.

My supervisors (experts in this field and in qualitative research methods) and I discussed these interviews and the feedback received during piloting to identify how the topic guide or my interviewing techniques might need to be adapted. There were several topics that were subsequently integrated into future interviews, including participants' awareness and experiences of 'being a woman' and if and how they perceived gender had impacted on their experiences (e.g. gender-based discrimination); relationships with family; and migrant women's experiences arriving in the UK (including experiences like detention). In addition, I re-worded some questions to avoid the use of terminology specific to a Western or biomedical framework ('mental health' or 'depression') or that was difficult to translate (e.g. the term 'stress' - instead I asked what experiences women felt had impacted on how they were feeling).

5.3.3.4.2 Cross-language interviews

For interviews requiring translation, I planned to use simultaneous translation with female professional credentialed interpreters. Prior to a cross-language interview I discussed with the interpreter the research aims, her role in the research, the questions included in the topic guide, the translated study literature, and translation methods (e.g. conceptual equivalence rather than verbatim; translating in the third person). She was also required to sign a confidentiality agreement to ensure that confidentiality and anonymity were maintained. I discussed the interview with the interpreter afterwards in order to gain any further insight, contextual information, or meaning (e.g. culturally specific meaning) that had not been translated during the interview, to gain her feedback on the interview and the topic guide questions in order to inform future interviews, and to learn more about her background (see chapter 2, page 50, for a discussion of the cross-language qualitative research methods).

5.3.3.5 Management of Data

Following each interview, recordings were downloaded onto a King's College London password protected computer, and then deleted from the audio-recorder. The interviews were transcribed verbatim in English (including cross-language interviews) by me or a member of the Section of Women's Mental Health (IoP, KCL). I also transcribed the

interview conducted in Spanish directly into English. I checked all transcripts to ensure they were anonymised and accurate.

Once finalised, anonymised transcripts were uploaded into QSR International's NVivo 8 qualitative data analysis software [481]. Hard copies of the anonymised transcripts were stored in a locked file cabinet at the Institute of Psychiatry. The coding framework was developed, then reviewed, revised and collated into themes using NVivo; paper copies of the transcripts were also utilised in the analysis (see section 5.3.3.7.2, page 182).

5.3.3.6 Ethical considerations

I aimed to ensure the research was conducted sensitively and appropriately, particularly because of the focus on stressful life events and because many of the women I was interviewing potentially were or had be in difficult situations. The methods were guided by postcolonial feminist research methods and good practice guidance on research methods for sensitive topics (summarised in Table 27) [326-333].

Table 27 Sensitive research and postcolonial feminist research methods†

Sensitive research and postcolonial feminist research methods	Implementation in this research
• Research with goals that benefit participants (e.g. producing knowledge that is translational and may benefit women); • Aims to give voice to underrepresented or marginalised populations (e.g. due to gender, ethnicity, migrant status, class, abuse).	• Aim for findings to inform social and health services for diverse communities of women (see 5.2 and chapter 8); • Diverse sample of migrant women and women born in the UK recruited; women were included regardless of English proficiency (see 5.3.2); • Qualitative methods used to enable person-centred approach; aim to acknowledge voices and perspectives of diverse sample of women (see 5.2, 5.3.3.4.1, and 5.3.3.7.2).
• Methods that are not coercive or oppressive, and do not put women at additional risk.	• Recruitment methods sought to minimise pressure women felt to participate, and to ensure the anonymity and confidentiality of their participation (see 5.3.3.2 and 5.3.3.5); • Aim to ensure women are fully informed of study and have capacity to consent prior to participation (see 5.3.3.2); • Aim to establish a non-hierarchical relationship in interviews (e.g. by recognising women were experts and the value of their contributions, giving women £10 to thank them for their time and contributions, enabling them to choose an interview location where they felt comfortable) (see 5.3.3.4); • Women were able to stop, withdraw from the study, or take a break at any time during the interviews if they

	were uncomfortable or distressed (see 5.3.3.4).
• Engaging with participants as active subjects and enabling them to define what is meaningful in the research.	• Topic guide structured to enable women to discuss their own perspectives and experiences, and to direct what was significant in the interview (see 5.3.3.4.1)
• Reciprocity	• Discussed with participant how she was feeling after the interview, and any needs she may have (see 5.3.3.4); • Provided information about support resources (see 5.3.3.4).
• Active reflexivity	• Engaged in continual process of active reflexivity throughout the research (see 5.3.3.8.3).
• Utilising women's language and concepts ('preserving their speech')	• Aimed for topic guide to be informed by what women defined to be meaningful (see 5.3.3.4.1); • In analysis, aimed to use women's language and concepts (see 5.3.3.7.2); • Excerpts included in results (see 5.3.3.8.1 and chapter 6).

†326-333

During the research I also participated in regular "clinical" supervisions with a psychologist who met regularly with researchers in the Section of Women's Mental Health. This forum is available to us to support us in this type of research, particularly as we hear about very distressing experiences which can impact on us.

5.3.3.7 Analysis

5.3.3.7.1 Descriptive analysis

Summary statistics were used to describe the socio-demographic characteristics of the migrant women and women born in the UK who participated in the study.

5.3.3.7.2 Thematic analysis

The data were analysed using thematic analysis. This method allowed me to focus on an 'insider perspective', exploring women's experiences, and the context within which they are situated. It was also an appropriate method to be used with the diverse (heterogeneous) sample of women included in this study, as it can be used in cross-language research [282] (see chapter 2, page 50), and its flexibility allows both similarities and differences (e.g. divergent themes) to be identified and explored. All data were analysed in English.

A narrative (chronological) framework informed the topic guide and analysis in order to identify and locate themes in relation to women's experiences across the life course, including prior to migration, during migration, and following migration. An ecological approach was also used in order to locate women's experiences in relation to the different ecosystemic levels in which they were experienced. Risk factors during the stages of migration and at different ecosystemic levels have been identified to be associated with psychological symptoms [19, 59, 339, 387].

Although a narrative framework and ecological model informed the topic guide and analysis, the analysis was inductive and data driven, and thus was theory building. This enabled the analysis to be rooted in the data and for the themes that were identified to reflect women's experience. In this 'bottom up' approach, the coding frame is developed through the interaction with the data, rather than seeking to fit the data into a pre-existing coding frame informed by the researcher's preconceptions or an existing theoretical model (though of course the researcher must acknowledge how their own background or preconceptions may inform their interpretations (see section 5.3.3.8.3). This enables the development of themes that are strongly linked to the data [482]. This was a useful approach for this study because I aimed to explore the insider experience for a diverse sample of women., and an inductive approach was suitable in order to pursue the study aims, and because there is no consensus in the literature regarding the relationship between migration and mental health.

5.3.3.7.2.1 Framing the Analysis

Prior to undertaking the analysis, several decisions were made regarding the analysis, informed by Braun and Clarke (2006). These are displayed in Table 28.

Table 28 Framing the analysis†

Framing question	Decisions made for analysis
What constitutes a theme?	Superordinate categorisations of codes (patterns) in the data representing significant experiences or constructs; not required to represent the entire sample.
Is prevalence or 'keyness' emphasised in development of themes?	Keyness; enabled exploration of experiences specific to a few individuals, or which were deviant cases.
Narrow framework (specific research questions or	Full exploration of data in order to encompass breadth and heterogeneity of women's experiences; however, themes focus

methodological constraints) or full description of data collected?	on central research questions (see 5.2 and 5.3.3.4.1).
Inductive or deductive?	Inductive; analysis was data driven, rather than informed by theoretical approach (e.g. 'migration-morbidity hypothesis', as there is a lack of consensus in literature regarding impact of migration on mental health), enabling me to explore 'insider perspective' for diverse sample of women.
Semantic (explicit) or latent (interpretative) themes?	Latent (interpretative) themes.
Positivist or constructionist approach?	Critical realist approach; between positivism and constructivism on spectrum. Recognises multiple realities: an individual's lived experience, and socio-cultural structures, beliefs, experiences, etc. informing it [482, 483].

†[482]

5.3.3.7.2.2 Stages of Analysis

The analysis followed the stages of analysis outlined by Braun and Clarke (2006) (see Table 29). The analysis used an iterative approach, and the appropriateness and validity of the codes and themes were checked by continually returning to the data.

Table 29 Stages of analysis†

Stage	My analysis process
Familiarisation	Immersion in the data, including listening to audio-recordings of interviews, transcription, proof reading transcripts, and repeated active reading of data in transcript form (detailed notes made, including initial patterns and codes identified). Notes and preliminary codes were continually reviewed.
Generation of initial codes	Content of entire data set was systematically coded in Nvivo 8 to identify initial codes. These were continually reviewed and compared with those identified during familiarisation.
Collation of codes into themes	Iterative, inductive, and interpretative process of reviewing codes and collating them to develop interpretative themes. Transcripts (data) were revisited to ensure any additional data previously uncoded were identified, and enabled codes to be revised and reformulated as necessary in reference to the data.
Review of themes	Themes were reviewed to ensure 'internal homogeneity' and 'external heterogeneity' (e.g. themes were distinct from each other, yet cohesive internally). This involved an iterative process of checking themes to ensure they were representative of the codes and data they described, and revising coding of data and themes where needed.
Defining and naming themes	An interpretative process through which I refined the themes and developed them by comparing themes to each other, and

	identifying sub-themes (to provide further insight into the meaning, significance, and structure of themes).

†482

5.3.3.8 Quality and rigour

I aimed to achieve quality and rigour throughout the research. Strategies to achieve trustworthiness and mechanisms to contribute to the quality and rigour of the research were incorporated throughout the study, which helps to ensure quality is obtained throughout the research processes of synthesis, abstraction, and interpretation, and to capture subtle but important processes during the research that may significantly affect the trustworthiness of findings (e.g. investigator responsiveness, skill, flexibility, or reflexiveness, or the appropriateness of the methods used) [484].

Strategies to increase trustworthiness, included applying quality criteria, conferring with researchers and community members in the coding and analysis, discussing findings with members of the community for whom the study was relevant, and engaging in active reflexivity to examine how my background may have impacted on the findings.

5.3.3.8.1 Quality criteria

In an attempt to achieve quality, I applied criteria identified in Cohen and Crabtree's review of evaluative criteria for qualitative research [325] and by Morse et al in their paper on verification strategies for establishing reliability and validity in qualitative research [484]. Because of the interpretative nature of qualitative research and the flexibility it requires, an emphasis on the quality of data and how representative the findings are of participants' experiences is necessary. The criteria followed are described in Table 30.

Table 30 Application of quality criteria†

Quality Criteria	Application in research
Ethical research Research is respectful, fair, and not coercive or exploitative	▪ Ethical review of research and approval by the Psychiatry, Nursing and Midwifery Research Ethics Subcommittee, King's College London (5.3.3.1). ▪ Aimed to use ethical consent procedures and non-coercive recruitment methods (5.3.3.2). ▪ Consultation with experts and piloting in an effort to develop a sensitive and appropriate interview guide (5.3.3.4.1).
Importance of research Advances knowledge in the subject	▪ Identified aims of research by reviewing relevant literature and identifying gaps (chapter 1), and

area and is beneficial to the community it represents	developed topic guide through discussion with stakeholders (e.g. individuals working with diverse communities of women and women themselves) (5.3.3.4.1). ▪ Aim to disseminate findings, including distribution to stakeholders working with diverse communities of women. For example, study findings have been presented at the British Afghan Women's Society, the American Public Health Association Annual Meeting, the Royal Society of Medicine's Shaping the Global Health Agenda Conference, the Institute of Psychiatry's Research Showcase, and the 4th World Congress on Women's Mental Health.
Clarity of report Research is presented in a clear, thorough, and transparent manner	▪ Aim to provide concise, thorough, transparent, and clear accounts of the methods and findings in this dissertation and any dissemination of findings (5.3 and chapters 5 and 6).
Appropriate and rigorous methods Selected methods are in line with the research aims and enable high quality research to be achieved	▪ Aim to use research methods informed by methodological and epistemological considerations (see chapter 2 and section 5.3).
Addressing researcher bias (e.g. reflexivity) Recognising the researcher's perspectives and their active role in the generation and interpretation of data	▪ Aimed to engage in active reflexivity at all stages of the research (5.3.3.8.3).
Validity or credibility; verification or reliability The relationship between the conclusions and the 'real' experiences of the participants; the results are consistent and generalisable. Given the interpretivist approach of this analysis 'validity' was prioritised over 'reliability', and the use of verification or reliability measures aimed to explore multiple realities, rather than determine a single 'reality'	▪ Collection and analysis of data occurred concurrently. The interaction between these processes contributes to the reliability and validity of the findings [484]. ▪ I sought to immerse myself in the data (5.3.3.7.2). ▪ In analysis aimed to use a reflexive, open, and iterative approach and to explore differences (e.g. deviant cases) as well as similarities (5.3.3.7.2). In order to achieve this as well as methodological coherence, I also aimed to ensure I worked inductively in order to ensure the process of analysis was consistent and any potential influence or bias recognised. ▪ Data were systematically checked, and the iterative process of analysis ensured the fit of data and the interpretative process was continually monitored (5.3.3.7.2.2). ▪ Themes were identified inductively (theory building), continually checked against the data, and further developed/modified where needed (rather than aiming to adhere to a theory). ▪ I aimed to examine the impact of my background and perspective on the findings through active reflexivity (5.3.3.8.3). ▪ I collaborated with other qualitative researchers in

	developing the coding framework in an effort to improve validity and to deepen understanding through examining multiple interpretations of the data (5.3.3.8.2). ▪ I discussed the findings with members of the communities for whom the research was relevant throughout the analysis process. ▪ I aimed to make the methods and interpretation of the data transparent to the audience (5.3 and 5.3.3.7.2). ▪ I aimed to provide detailed presentation of the findings; in the results excerpts (data) were included to support themes (chapter 6).

†325, 484

5.3.3.8.2 Conferring with researchers and community members

I sought to enrich findings and improve validity by conferring with both members of the community to whom the research was relevant and other qualitative researchers during the development of the coding framework, during the analysis, and once the study was completed. The aim was to deepen my engagement with the data, examine multiple interpretations of the data, and share the research with the communities to whom it was relevant [325, 485].

I collaborated with two researchers in the Section of Women's Mental Health who had been involved in the transcription of the qualitative interviews and were immersed in the data. Both of these researchers were migrants to the UK. I asked each of these researchers to independently code seven interviews (14 in total). After I had conducted an initial coding of all data (see Table 29), the researchers and I discussed our coding in depth, referencing the transcripts. Where there were discrepancies in our interpretations, we collaborated to revise the coding and our conceptualisations to better reflect the data. This process informed the development of the coding framework. My primary supervisor also read the transcripts for all interviews, and throughout the coding and generation of themes, I discussed the data and analysis with my supervisors (one of whom was born in the UK, and one of whom is a migrant to the UK) in great detail.

I also discussed the analysis with women born in the UK and women who had migrated to the UK. For example, during analysis I discussed the codes and themes I was identifying with members of the British Afghan Women's Society and sought their feedback regarding their own experiences and the relevance of the themes to their

community. I also shared the findings of the research with this organisation once the qualitative study had been completed.

5.3.3.8.3 Reflexivity

I aimed to contribute to the quality of the research by engaging in a process of active reflexivity at all stages. Through this process I was not trying to remove my influence on the findings or isolate bias (as suggested by a positivist approach assuming a single 'truth' exists), but rather to acknowledge multiple realities: the data are grounded in an individual's experience and informed by the greater context within which they live, however the context within which the research is conducted may also impact on the findings [325, 486-488]. Through this introspective process I sought to examine how my background, perspectives, and experiences (informed by my gender, migrant status, ethnicity, and social class), may have affected how I was perceived by the women I interviewed, my relationships with them, the data generated, and my interpretation of it.

I felt that being a woman had positive implications for the research. It enabled the presence of woman-centred language, experience, and meaning in interviews and analysis, contributing to the representation of women's voices in the research [327]. I also felt our shared identity as women facilitated the ability to discuss experiences like abuse, sexual violence, or gender-based discrimination, and the shared aspects of our experiences as women had the potential to break down barriers [327, 328, 489].

My background as a migrant to the UK was also relevant in the context of this research. In some respects, being a migrant afforded commonalities in experience between myself and the migrant women I spoke with relating to distance from family, unfamiliarity with a new place, and the challenges of negotiating the systems in the UK (e.g. interacting with the UK Border Agency, accessing the NHS, working, even setting up a bank account or renting accommodation, which often have specific requirements and limitations for migrants). However, I was also aware of how my experience as a migrant was very different from many of the women with whom I spoke.

My legal status in the UK is secure as my student visa enables me to reside in the UK for the duration of my studies. In addition, I am able to return home relatively frequently, and have no fears relating to the conditions in my country of origin. Many

of the women I would interview would be unlikely to have a secure legal status in the UK (e.g. asylum seekers), and could face the prospect of detention or deportation if their applications are not successful. In addition, often the circumstances to which they would be forced to return hold further stressors for them. I also reflected on how the experience of migrating would be very different (and far more challenging) for migrant women who had fewer financial resources, than it had been for myself. I sought to be reflective about how these differences might have affected the interviews, for example how much women might have discussed these concerns with me if they perceived that I did not share the same experiences of financial instability that they had, or because of a fear of judgment because of their financial situation.

Our experiences as migrants may also have been informed by, and differed because of, our ethnicity and language proficiency. Being a white migrant and proficient in English is likely to have facilitated my experience of migration to and integration in the UK because I am perceived to be a part of the majority and did not experience significant barriers due to language. Though I have an American accent, which makes me recognisable as a migrant when I speak, I am likely to have experienced less discrimination in the UK because of my migrant status, ethnicity, or language proficiency than many of the women I planned to interview. Many of these women would be more identifiable as migrants than I am, would not identify as white or speak English as a first language, and many would be likely to be 'othered', stigmatised, or discriminated against because of these factors. I was also aware that these characteristics might have been perceived to be significant differences between us, and ultimately may have impacted on my relationship with the women I interviewed and the topics we discussed. This could be due to perceived differences in our experiences, the social structures and power hierarchies relating to these factors, fear of judgment or discrimination, what women felt comfortable discussing with me, or what was perceived to be 'acceptable' to discuss or relevant to my research interests).

My migrant status and ethnicity were also important to consider in the context of my interviews with women born in the UK. The differences in our experience of life in the UK (for example in relation to our ethnicity, and the power hierarchies surrounding this including discrimination, marginalisation, and other forms of oppression) could impact on the interviews. I needed to be aware that women might not discuss certain

experiences if they perceived I did not share those experiences, if they anticipated judgment or discrimination, or perceived I would not be interested in their experiences. Furthermore, women's political views relating to migration might affect their views of me.

The political issues in the UK surrounding migration also informed the context within which my research was conducted. During the course of my PhD, I have had (sometimes heated) discussions with acquaintances about migration issues, been pressured to justify my research, and had my own migrant status commented on (including by participants).

My engagement in the interviews with both migrant women and women born in the UK would be influenced by my own experiences and assumptions; in some cases I may have ultimately had a lack of insight into meaningful topics for the women I interviewed because of differences in my own experiences or my assumptions. To address this, I sought to enable women to direct the interviews or define what was meaningful, which was facilitated by the structure of the topic guide (see section 5.3.3.4.1, page 178). However, both in the interviews and the analysis I aimed to recognise that my own perceptions may have limited my awareness surrounding certain topics or what topics I perceived to be significant and thus focused on.

Chapter 6: Qualitative study of the mental health and well-being of migrant women and women born in the UK: Results

6.1 Introduction

In this chapter, I present the results of a study investigating what experiences impact on women's mental health and well-being and how women are affected through in-depth qualitative interviews with migrant women and women born in the UK living in London. First, I will provide summary statistics to summarise the characteristics of the women who participated in these interviews. Then I will describe the types of stressful life events women perceived had an impact on their mental health and well-being, providing excerpts to illustrate women's experiences of these events. Following this are the results of a thematic analysis in which I present themes relating to processes contributing to women's experiences of stressful life events and their mental health and well-being, and women's conceptualisations of their mental health and well-being.

6.2 Summary statistics

6.2.1 Recruitment

Thirty women were recruited for this study including 20 first generation migrant women and 10 women born in the UK.

Twelve of the participants were recruited from community organisations in London. I contacted a total of 19 organisations. I recruited participants from six of these organisations including: the British Afghan Women's Society (n=1), The Kiran Project (for Asian women experiencing domestic violence) (n=1), Praxis Community Projects (advice and support for 'vulnerable' migrants in London) (n=3), the Refugee Council (n=3), the Sudan Women's Association (n=2), and the Somali Refugee Council (n=2).

34 women who had previously participated in the SELCoH study were invited to participate in this study. Of these, 18 elected to participate, including 10 migrant women and 8 women born in the UK. 12 women could not be contacted, and 4 declined to participate. There were no significant differences in the distribution of the socio-demographic and psychiatric characteristics of women from the SELCoH study who

elected to participate, and women I was unable to contact or who declined to participate (see Table 31).

Table 31 Socio-demographic and psychiatric characteristics of participants and non-responders from the SELCoH Study (n=34)

Characteristics	**Participants n=18 (52.9%)**		**Unable to contact n = 12 (35.3%)**		**Declined to participate n = 4 (11.8%)**		***p-value***
	N	**(%)**	**n**	**(%)**	**n**	**(%)**	
Migrant status							*0.79*
Non-migrant	8	44.4	6	50.0	1	25.0	
Migrant	10	55.6	6	50.0	3	75.0	
Ethnicity							*0.75*
White	6	33.3	5	41.7	1	25.0	
Black – Caribbean	1	5.6	1	8.3	1	25.0	
Asian and Other	11	61.1	6	50.0	2	50.0	
Age	18		12		4		*0.18*
Mean (s.d.)		48.8 (17.1)		37.3 (17.8)		73.8 (10.8)	
Median (25^{th} and 75^{th} percentiles)		45 (38, 60)		32.5 (26, 39)		70 (66, 81.5)	
Range		(21 – 81)		(19-76)		(66-89)	
Mean years in UK	10		6		3		*0.22*
Mean (s.d.)		19.1 (12.4)		9 (10.7)		27.3 (20.5)	
Median (25^{th} and 75^{th} percentiles)		15.5 (10, 19)		5 (3, 10)		22 (10, 50)	
Range		(7 – 46)		(1 – 30)		(10 – 50)	
High levels of non-psychotic symptoms[††]							*0.59*
No	13	72.2	10	83.3	4	100.0	
Yes	5	27.8	2	16.7	0	0.0	

6.2.2 Socio-demographic characteristics of participants

6.2.2.1 Women born in the UK

The mean age of women born in the UK was 47 years [s.d. 26.7, range 22-84]. Eight of the women born in the UK were mothers, with a range of 1-3 children. The ethnicity of women born in the UK included White (n=5), Black Caribbean (n=1), South Asian (n=3) and 'other' (n=1). Among these, three women were second generation (children of migrants).

6.2.2.2 Migrant women

The mean age of migrant women in the sample was 40.6 years [s.d. 12.54, range 18-70]. Twelve of the migrant women I interviewed were mothers, with a range of 1-7 children. The countries of origin of the migrant women included Japan (n=1), Pakistan (n=3), India (n=1), Bangladesh (n=1), Sudan (n=2), Eritrea (n=1), Somalia (n=2), Kenya (n=1), Cameroon (n=1), Morocco (n=1), Mauritius (n=1), Cyprus (n=1), Trinidad and Tobago (n=1), Columbia (n=1), the United States (n=1), and Sweden (n=1). The mean number of years the migrant women in the sample had been in the UK was 16.21 years [s.d. 10.3, range 7-49].

Among the migrant women I interviewed, eight explained they had migrated because they were fleeing life in their country of origin, including violence, conflict, or discrimination. One of these women was ultimately trafficked to the UK. Another woman had initially migrated for her partner, but later sought asylum in the UK. Six of the other migrant women I spoke with told me they had migrated for their families or a partner. For many of these women, there was no 'choice' in the decision to migrate as they were expected or forced to emigrate from their countries of origin. Five women migrated for a "better life", which included for education, work, or improved quality of life. In the results, the reason for migration indicated with the included excerpts reflects women's status when they first entered the UK.

The migrant women I spoke with had experienced a range of legal statuses (or migration statuses). Women had migrated under study or work visas, under family visas or as dependants, as visitors (e.g. visitor visas), and as EU nationals (and thus were able to reside and work in the UK). There were also migrant women who did not have (or at

some point had not had) 'leave to remain'. This included asylum seekers (some of whom had been grated leave to remain as refugees), and women who had been in the UK 'illegally', including failed asylum seekers, women who had entered without claiming asylum or having a visa (several women who were dependants described that those they were dependent on had not acquired visas for them), and women who had overstayed their visas.

6.3 Stressful life events perceived to impact on mental health and well-being

In the narratives women identified a range of events that they felt negatively impacted on their mental health and well-being including abuse, witnessing violence, stressful events relating to close relationships, and physical health events. The relationship between these experiences and women's mental health and well-being is illustrated in their excerpts below. These events were often interrelated, and in some cases were cyclical. Over the life course women described experiencing multiple stressors simultaneously and chronic or relentless exposure to stressors.

Suffer from long time and…I'm still suffering…From sadness to sadness, from death to death…it was horrible life (participant 9, migrant (trafficked)).

6.3.1 Abuse

Women described experiences they found 'hurtful' or 'abusive' in the narratives including psychological or emotional abuse (including verbal abuse, coercion or control, or intimidation), physical violence (including violence during pregnancy and forced abortions), sexual abuse (including verbal and physical harassment, and rape), and exposure to unhealthy living conditions (e.g. deprivation, neglect, or forced labour). As I will show in the narratives presented in this section, women described associations between their experiences of abuse, and feelings of anxiety and fear, a loss of self-esteem, feeling sad or down, and a loss of trust.

In the narratives, abuse was predominantly perpetrated by family members, guardians, or partners. Often women were in positions of powerlessness in relation to the perpetrators of this abuse (e.g. as children, due to financial or legal dependence, isolation, or lack of support resources). These imbalances of power made women feel

they were more vulnerable to it, or less able to stop it or cope with its effects on them (see section 6.4.1.2, page 218 for a discussion of disempowerment).

These experiences were startlingly prevalent; 21 women disclosed experiences of abuse, including 13 migrant women and eight women born in the UK. Ten migrant women disclosed psychological or emotional abuse (all in adulthood), six had experienced physical violence (two as children), five disclosed a form of sexual abuse (one in childhood), and five described being exposed to unhealthy living conditions (all in adulthood). Among the women born in the UK, seven revealed psychological or emotional abuse (one during both childhood and adulthood, and another during childhood only), three reported physical violence (two during childhood), two disclosed sexual abuse (in adulthood), and three described being exposed to unhealthy living conditions (one in adulthood, and two in childhood).

For many women I spoke with, abuse was chronic, continuing to be experienced for the duration of time they remained in contact with the individuals perpetrating the violence. Eleven women reported experiencing multiple types of abuse over their lifetime, including eight migrant women and three women born in the UK. Often, multiple types of abuse were experienced concurrently (e.g. verbal and physical abuse). Women also experienced violence across multiple relationships, including in consecutive partnerships, or by multiple individuals concurrently (for example partners and in-laws). Women described that the constancy of abuse resulting from these patterns was overwhelming, exacerbating the effects it had on their emotional health, as well as their physical health (e.g. sustaining multiple injuries).

[My husband] beat me…[I'm] hurted from my [in-laws]…it's too much for me to cope…my anti-depression is increasing, and my sleeping problem is increasing (participant 12, migrant (migrated for partner)).

6.3.1.1 Psychological or emotional abuse

One of the forms of psychological or emotional abuse women described was the use of verbal abuse, which was often perpetrated by partners or family members, and was perceived by some women to be more detrimental than physical abuse.

Talking is really bad thing. It really straight going my heart…really worse. If you don't like me instead you just slap my face…I'm saying always [to] my husband, "If you

anything hurts my body…or your mom give a slap, I don't mind…You people is really bad talking" (participant 22, migrant (migrated for partner)).

It just made me feel like really insecure about everything, every part of me…"This is what you're supposed to look like"…"You're fat"...He said very hurtful things (participant 3, born in the UK (second generation)).

In some cases verbal abuse was associated with discrimination or racism, and perpetrated from the community.

Sometimes the children abuse to me…probably they don't distinguish Korean, Chinese, Japanese…children stood by the bicycle and a very "stinky stinky" quote: "I don't like garlic" or something like that…every car something open the window and shout something (participant 27, migrant (migrated for a better life)).

Kids will go like, "Look we have a Paki in our house"…It was very personal and very hurtful and it stayed in my mind for a long time (participant 21, born in the UK (second generation)).

Women also disclosed abuse consisting of coercion or control, and the use of intimidation or threats. Women described this was associated with feelings of fear or anxiety, as well as a feeling of powerlessness resulting from their fear of the perpetrator, and the consequences if they disobeyed or challenged them.

He would get so angry he would chuck the television across the room…I would say no [to sex] and then he would get angry…I felt trapped because I couldn't' leave. Because if I walked through the door he would get even more angry (participant 3, born in the UK (second generation)).

For many women, this fear persisted after the abuse had stopped or after the end of relationships with the perpetrators. In some cases, abuse also resulted in a loss of trust, and led to women's self-isolation, which also had an effect on women's mental health and well-being, and presented barriers to accessing support (see section 6.4.1.3, page 224).

[My husband] always promised me that if I ever leave him, I'm going to die a brutal death…I would wake up in the middle of the night… feel someone's looking at me... Really scary. That's the after effects of it now (participant 11, migrant (migrated for asylum)).

I can't talk to men...My GP was a man; I couldn't see him or talk to him about anything (participant 3, born in the UK (second generation).

6.3.1.2 Physical violence

In the narratives women also disclosed experiences of physical violence, which often accompanied psychological or emotional abuse. These experiences were disclosed more frequently by the migrant women I interviewed than women born in the UK.

[My dad] pushed me about…hit me like close to my face…my mum was just slapping me all the time (participant 3, born in the UK (second generation)).

He would grab my hair, really bang my head on the wall…For the couple of seconds or minutes, you don't even feel if your body is aching or he's done something or you're bleeding…it leaves a space…you feel humiliated (participant 8, migrant (migrated for partner)).

In addition to the impact it had on women's mental health, physical violence also resulted in injuries, which often affected women for an extended period of time, and in some cases permanently.

I've got metal plates…I've got a scar there…got punched in the eye… the retina is bruised. I can't see properly with this eye. My teeth they're all not mine (participant 11, migrant (migrated for asylum)).

Several of the migrant women I spoke with also disclosed experiencing physical violence during pregnancy, including forced abortions. This abuse reflected the abuser's control of the women's bodies and their reproduction, and was perceived to be psychologically and sexually abusive, as well as physically abusive.

The first time I was pregnant he grabbed me and pinned me against the wall, his hand on my neck and he said, "You have to abort the baby"…I took the pills and after one hour the baby was gone. I stayed under the shower for more than four hours that day…lying in the water…I was disgusted with my body… crying because…of what happened earlier (participant 8, migrant (migrated for partner)).

The injuries sustained from these forms of abuse were particularly salient as they often resulted in long term physical consequences (like being unable to bear children).

I had a…bamboo stick…shoved up my vagina to get rid of the baby…I started to bleed really badly…I thought I was going to die with the pain…I still get symptoms…obviously that led to nothing [being able to have children] because it was damaged and stuff (participant 11, migrant (migrated for asylum)).

In some cases, physical violence also resulted in injury to the foetus, or miscarriages. The loss of a baby (either through miscarriage or forced abortion) impacted on the women's emotional well-being, in addition to the effects of the violence itself.

There is a time my husband hit me and the baby die. Nine months baby...die in my tummy. They have to take me hospital…to remove the dead body…it was horrible (participant 9, migrant (trafficked)).

A further example of physical violence that impacted on women's sexual and reproductive health was 'female genital mutilation' (also known as 'circumcision' or 'cutting'). This resulted in physical injuries that often had long term implications for women, for example relating to their menstruation, sexual activity, or health (e.g. chronic pain or infection).

[The circumcision] was really a bad experience…It takes you…months to heal the place…I [still] feel pain (participant 6, migrant (migrated for asylum)).

6.3.1.3 Sexual abuse

Women disclosed experiences of sexual violence (including verbal and physical sexual abuse, and rape). This violence was perpetrated by partners, family members, acquaintances, and in some cases strangers. These experiences were defined by the forced or coercive nature of the sexual abuse, and often resulted from women's powerlessness in relation to the abuser (achieved through threats, physical violence, social or cultural expectations, or because of women's dependence on perpetrators (e.g. financial or legal)).

I'd say, "I don't want to." He would get angry…I'd feel bad because…I just felt like I owed him something…I had no choice…He was paying rent…"Oh, so are you just using me or something?"…I wasn't using him, but you know I didn't have anywhere else to go (participant 3, born in the UK (second generation)).

In some cases sexual abuse resulted in physical injuries.

[My husband] brought men in the night…come attack me…they 'shame' [rape] me… He break all my body…I couldn't walk straight, but now because I go to hospital and they put me in this exercise…they start with physical therapy then they put me into hydro therapy (participant 9, migrant (trafficked)).

Women also described that these experiences had an emotional or psychological impact, or were associated with feelings of loss (e.g. of self-worth, virginity), disgust (with the perpetrator or themselves), shame, blame (imposed by themselves or their community), and a loss of trust. These effects were not only acute; the impact of sexual abuse persisted for many years for some women.

I'd done things for the first time with him…even though I didn't like him…It was horrible…[now] I don't trust [men]… even when I'm fully clothed I feel exposed…I have nightmares cause of the things that he'd done (participant 3, born in the UK (second generation)).

Following experiences of sexual violence, in particular rape, women also experienced repercussions at the community level. Several women described the stigmatisation they experienced following sexual violence because of the social or cultural expectations relating to women's bodies and virginity (see section 6.4.1.1, page 207 about marginalisation).

I suffer a lot, he do horrible things for me, but I can't return [home]…[My auntie] say, "…You can't stay here because you know you're not belong here"…[My step-brother] say, "…you have to suffer…because we can't take you back" (participant 9, migrant (trafficked)).

6.3.1.4 Unhealthy living conditions

Women were also exposed to unhealthy living conditions (including forced labour or exploitation, deprivation, or neglect). In some cases this form of abuse was utilised intentionally, often as a method of control or punishment.

I was locked in a room crawling around, doing everything on the floor. I had to beg for food…I would only cooperate just to get food (participant 11, migrant (migrated for asylum)).

I've lost a lot of weight…When he goes to work I'd try to find food to eat…I can't…when he's there cause he'll say…"Oh what are you doing – did you buy that?" (Participant 3, born in the UK (second generation)).

Women were also subjected to deprivation or neglect due to the negligence or ignorance of the perpetrator. This was most often described by women who were in a subordinate position to the perpetrators of the abuse, for example dependent on them financially, legally, or for their care.

We were looking after [my mom]…cause she was drinking…We had to do our own dinners…We were living in a dirty environment…We had to try and clean it and we're like what seven and six years old (participant 19, born in the UK).

Some women's exposure to unhealthy living conditions occurred at a systemic level. One of the most prominent examples related to the deprivation or poor quality of life women without leave to remain (e.g. asylum seekers) were subjected to. These women attributed this to the limited resources available to them, and the infrastructure of the immigration system.

Without house, without food, without nothing, now very cold…I don't know what is going on [with my asylum application]…Where is human right?…You know is Home Office…it is not life (participant 5, migrant (migrated for asylum)).

6.3.2 Witnessing violence

Women also talked about the impact of witnessing violence, including conflict or interpersonal violence, and the insecurity or fear they felt as a consequence. Two of the women born in the UK had grown up during war time in the UK and had some memories of the conflict.

Towards the end of the war…we were evacuated…I remember that we were rationed…there were troops stationed in the town I lived in…everybody was very concerned (participant 26, born in the UK).

Exposure to conflict was predominantly described by the migrant women I spoke with, however, who had experienced it in their countries of origin.

You live with a fear…when you see all these soldiers and you know they could fire or they could shoot you…and you see this big tanks and big guns…it is scary…you want to get out of that…environment (participant 18, migrant (migrated for a better life)).

There was bomb that you were hearing…It was really scary…It even have an impact in me even now...I sometimes wake up in the middle of the night…like scared (participant 6, migrant (migrated for asylum)).

Women also talked about how witnessing interpersonal violence in their homes or communities impacted them.

It would…worry me…You'd expect to come home and see a new bruise on [my mom]. That's how bad it was…It really did affect us…[It was] scary, like you wanna run in and protect your mum, but you can't because you feel like what's gonna happen to you? (Participant 23, born in the UK).

In some cases the violence women witnessed (e.g. interpersonal violence), corresponded to stressful life events experienced by friends or family.

6.3.3 Stressful events relating to close relationships

In the narratives, women spoke about the salience of stressful events relating to close relationships. These events included the loss of relationships, the stressful life events of friends and family, and relationship stressors.

The loss of relationships, including the death of or separation from friends and family, was experienced by nearly all of the women I interviewed, and was associated with feelings of sadness, isolation, and a loss of emotional support. Being taken into care

was one of the situations in which women were separated from family, and was only described by women born in the UK.

I remember that day to this day when [social services] all come and they took us. It was horrible...it was like, "I don't want to. I don't want to go!" (Participant 19, born in the UK).

Women also spoke about the death of friends or family. For women in the UK, this was most frequently due to accidents, illnesses, or old age.

[My husband] became ill…There was no cure. And then three years in total and then he died…It was the worst year of my life (participant 30, born in the UK).

She and I were really close…It was a bad death…she was in pain and that was hard to see. And it was hard to see her body change (participant 25, migrant (migrated for better life)).

Women also described experiencing miscarriages, and the sense of loss that accompanied this.

Last week I had a miscarriage…[I'm] so emotional…That mentally has affected me…It kind of brought something on a high and suddenly on a low (participant 21, born in the UK (second generation)).

I lost two babies…It's horrible, especially the first one. I was 6 ½ months...You think you're not going to be able to have a child. And then when I lost a second one…it's worse (participant 18, migrant (migrated for a better life)).

In addition to these experiences, migrant women also spoke about the death of or separation from friends or family due to the conditions in their countries of origin, for example violence or conflict.

[My husband's] death happened because the guerrilla killed him - and my brother (participant 13, migrant (migrated for asylum)).

Migrant women also experienced separation from their friends or family because of their migration. Their reasons for migration, legal status, and financial barriers (e.g. to travelling) often necessitated prolonged, and in some cases, permanent separation from family and friends.

I left behind my family…my husband…my daughter…now she grown up, I don't even know her…I'm a mother; you miss your daughter for about seven years. Is that alright?! (Participant 10, migrant (migrated for asylum)).

You have not heard or seen how your mother's looking like… if she's gained weight…if she is starting to grey…the last time I saw her it was ten years ago…So I don't remember exactly how she looks…you get sad after a while (participant 1, migrant (migrated for asylum)).

Both migrant women and women born in the UK talked about the impact that stressful life events experienced by friends or family had on them. These included exposure to violence (e.g. conflict or interpersonal violence), serious accidents, illnesses, or poor living conditions. Women described the anxiety they felt in relation to these events because of their powerlessness to help their loved ones, and their fear of losing them.

[My mum is] in hospital all the time…She had major scare, she actually went flat line…that was when I was like "Oh my God"…I get told everything that's happening…then that's all I can do really (participant 19, born in the UK).

People are suffering... your own blood family, my husband or my daughter… I'm talking about your own flesh! You can't help! (Participant 10, migrant (migrated for asylum)).

These experiences sometimes involved caring for others, and the responsibility (and in some cases stresses) involved in that role.

My dad has Alzheimer's...my siblings were trying to make it work and we just didn't cope…There was no book about what to do…it was incredibly stressful for everyone (participant 25, migrant (migrated for a better life)).

One of the other stressful events relating to close relationships described by the women I interviewed was relationship stressors (e.g. conflicts with family members and partners), which were associated with feelings of anger, anxiety, and in some cases fear.

We were always arguing…I'd say to him go away. Seriously pack your stuff. Go. I don't want you here no more…It was really hard (participant 19, born in the UK)

[My partner and I] would be shouting and screaming …it was just terrible…It's certainly had an impact, I didn't realise, until much later (participant 20, migrant (migrated for partner)).

For many women, these conflicts were associated with other stressors, for example abuse.

Somehow it was always my fault and you know, it's kind of going down slowly and then eventually we were on the beach one day and had an argument, it was night and he hit me, uh slapped in my face (participant 15, migrant (migrated for a better life)).

Among the migrant women and second generation women I spoke with, family conflicts (particularly in relationships with parents, children, or in-laws) were often due to differences in social and cultural values, or changes in them (e.g. due to acculturation).

I'm still angry. Cause we have a culture…Every family they got their own qualities, doesn't matter what culture you are…and you want to carry that quality. [Our daughter] spoiled our family (participant 18, migrant (migrated for better life)).

Our parents are sometimes quite narrow minded…it causes arguments…my way of thinking is slightly different to my mum's…my mum says to us that we're Westernised… because we have a different way of thinking…so that kind of creates conflicts (participant 4, born in the UK (second generation)).

6.3.4 Physical health events

Many women had experienced significant physical health events throughout their life-course. These events were predominantly related to old age, a serious illness or accident, or reproductive health. In addition to the physical effects of these events, women talked about their feelings of anxiety, worry, sadness, and frustration in relation to these events.

There were four women born in the UK, and one migrant woman in the sample who were aged 60 or older. These women described physical health events more frequently than the younger women I interviewed. Age related health events included chronic pain, arthritis, injuries from falling, operations, loss of strength, neurological problems, and heart problems. These age related events often resulted in limitations in women's functioning and activities.

I'm too old…it's arthritis of the spine…it's gonna be stopping me doing anything…Even if I went out shopping meself I couldn't lift the shopping up (participant 29, born in the UK).

Women also described health events relating to a serious accident or injury. These events were often sudden or unpredictable, and for many women occurred when they were otherwise healthy. These events were often traumatic in themselves, and in many cases resulted in long-lasting pain or debilitation.

I had a…bad bicycle accident…in my 20s…It wrecked my running…it's been frustrating now for 20 years…because I would have pain (participant 25, migrant (migrated for a better life)).

Women also experienced physical injury following abuse (e.g. physical or sexual violence), which is discussed more in sections 6.3.1.2, page 197 and 6.3.1.3, page 199.

The serious illnesses women described included cancer, tuberculosis, and diabetes. The meaning of these health events was related to the risks associated with them, and the impact (e.g. disruption) it had for their lives and functioning, both acutely, but also longer term.

I had a breast cancer…I'm really really sad, because I'm thinking…I'm not live... when I'm dying, nobody looking after my kids…Still not now I'm not feeling physically good…a little bit work and my hand and my body is quickly tired (participant 22, born in the UK).

Women also experienced health events relating to their reproductive health. In some cases, these events had significant implications, for example women's ability to have children in the future.

Did IVF [in vitro fertilisation] for a few times, but just didn't work… it was traumatic and it was painful (participant 25, migrant (migrated for a better life)).

6.4 Results of the thematic analysis

In the thematic analysis I identified: 1) processes contributing to women's experiences of stressful life events and their mental health and well-being; and 2) women's conceptualisations of their mental health and well-being. The relationship between these factors is presented in (Figure 3).

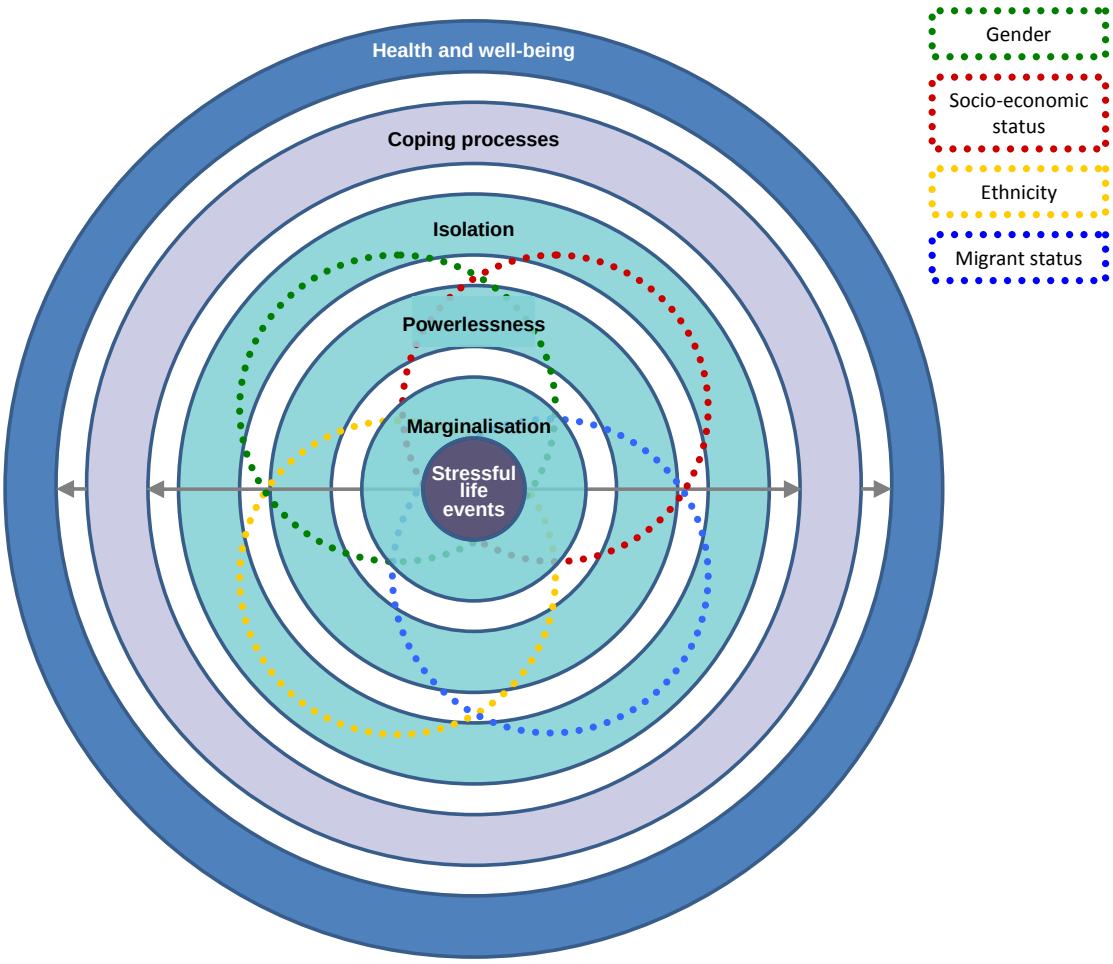

Figure 3 Experiences impacting on women's mental health and well-being

6.4.1 Processes affecting women's mental health and well-being

In the analysis, I identified four processes contributing to women's exposure to stressful life events and impacting on their mental health and well-being: *I'm outside of world* [marginalisation], *You're not as free as you want to be* [disempowerment], *You feel alone in the battle* [isolation], and *This gave me strength* [coping processes].

The first three processes (marginalisation, disempowerment, and isolation) were perceived to negatively impact on women's mental health and well-being and to limit their access to coping resources. The excerpts included in the results describe these processes, as well as how they affected women's mental health and well-being.

Marginalisation is at the core of these three interrelated processes. Women were marginalised because of their gender, socio-economic status, ethnicity, and migrant background. These marginalised statuses often intersected. The social exclusion and oppression women experienced because of these statuses contributed to their disempowerment and isolation. In the results, these three processes will be discussed in relation to these statuses.

The fourth process, *This gave me strength*, describes the coping processes that enabled women to address the effects of stressful events and marginalisation, disempowerment, and isolation on their mental health and well-being.

The relationship between these four processes is presented in Figure 4.

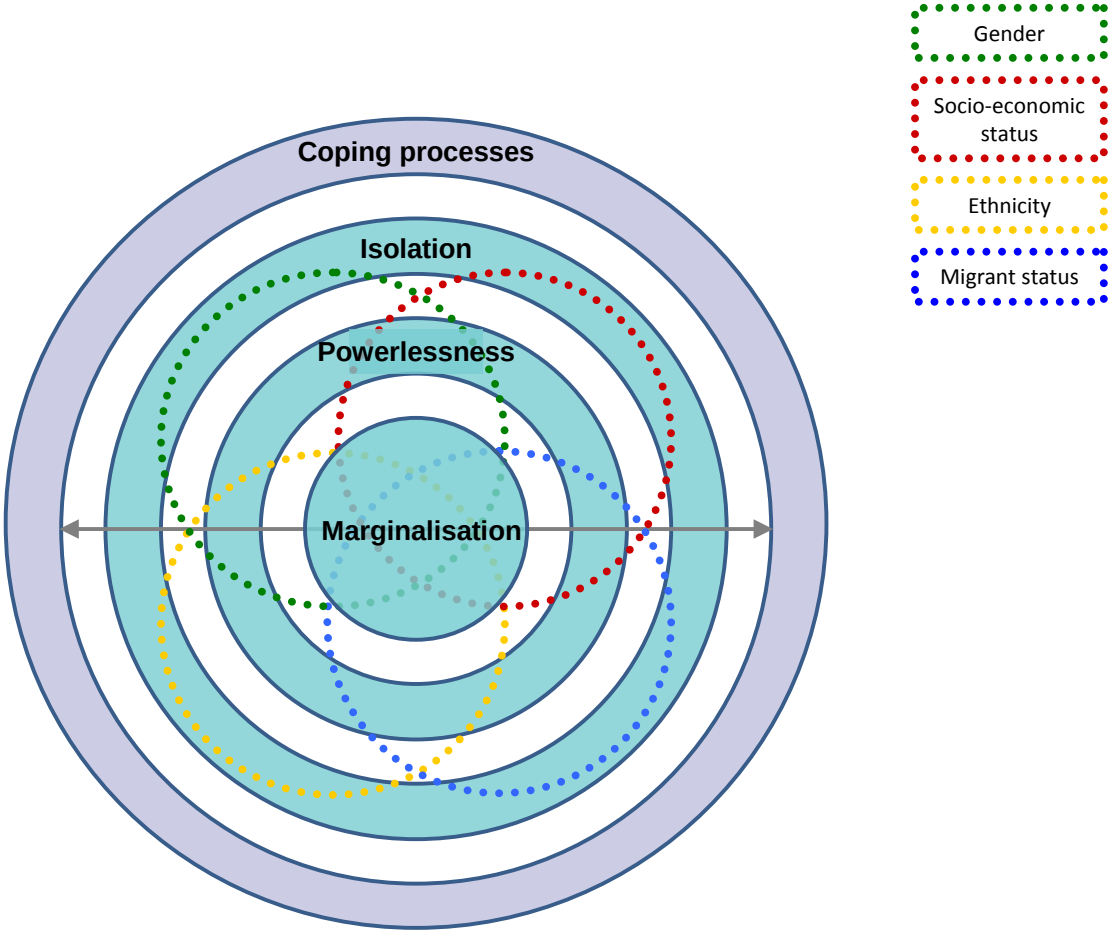

Figure 4 Processes impacting on mental health and well-being

6.4.1.1 "I'm outside of world" - Marginalisation

Marginalisation was at the root of the processes impacting on women's mental health and well-being. As the excerpts included in this section show, women described that their experiences of marginalisation were associated with feelings of anxiety, sadness, worry, loss of self-esteem, and presented barriers to coping, one of the most important of which was restricting their access to health services.

Women were marginalised at the micro-level (e.g. in their relationships individuals like friends, family members, or partners), the meso-level (e.g. by their communities), and the macro or systemic level (e.g. by the state or media). Often women were marginalised in multiple relationships across these ecosystemic levels. The social inequalities, discrimination, and oppressive power relations they confronted across these ecosystemic levels were predicated on their gender, socio-economic status, ethnicity, and migrant background. These statuses often intersected, resulting in 'multiple marginalisation'. After identifying the multiple marginalisation women were describing

in their narratives in the analysis, I applied this ecosystemic framework in order to structure how I described women's experiences of multiple marginalisation (and similarly of disempowerment and isolation) in the results.

Migrant women in particular talked about being marginalised because of multiple statuses, for example their minority ethnicity, English proficiency, legal status, socio-economic status, and gender, which were often interrelated. Occupying multiple marginalised statuses resulted in increased oppression, exclusion, and barriers to accessing support resources.

They say they don't like me because I'm from Sudan…cause I also have no education, I don't have a degree, I come from a poor background (participant 1, migrant (migrated for asylum)).

Though these marginalised statuses are described individually here, it is important to be aware that they often overlapped, and that their intersection informed women's lived experience.

The marginalised statuses and sources of marginalisation described in the interviews are presented in Figure 5.

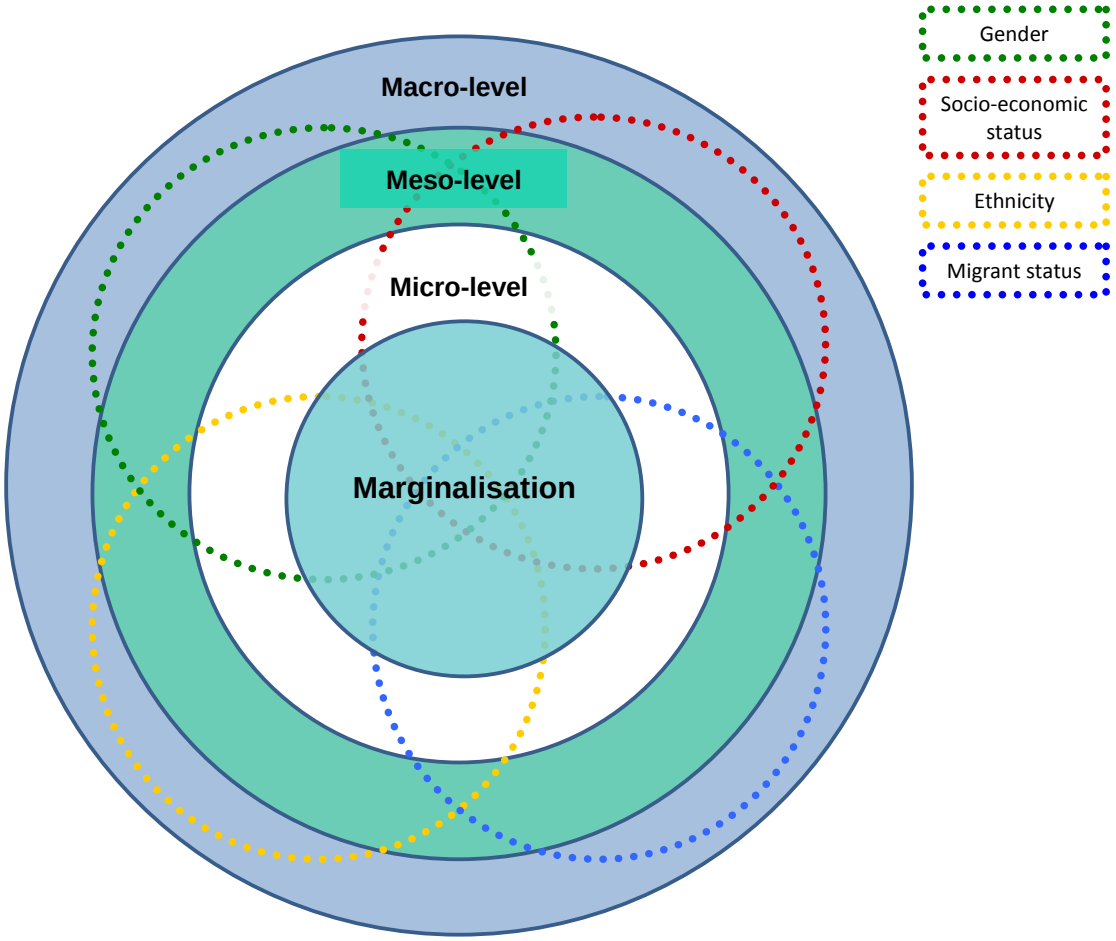

Figure 5 Outside of world

6.4.1.1.1 Gender

In the narratives women described how they were marginalised because of their gender, and the lack of value they had socially compared to men. Women described that this marginalisation impacted on their self-esteem and well-being.

It's just bloody difficult to be a woman in relation to men…it certainly feels like they actually don't really see me as a human being…as an equal person to them… "You can treat a dog like a dog"…They sort of break you down, and it's slowly over time that you lose that sense of self (participant 15, migrant (migrated for a better life)).

Women spoke about differences in how they perceived they were treated compared to men in relation to their social roles, accepted behaviour, and rights. Women described attitudes within their families, communities, or at a structural level that were discriminatory, including the expectations and restrictions they faced relating to their social roles.

My mum thinks that I should be doing everything and is a bit shocked that I make my husband do things…my husband comes from a similar…family…Though he'd never kind of say, "I want you to be at home all the time," I think…he'd choose that (participant 14, born in the UK).

[I told] my parents that I don't think this marriage would work…"You can't [divorce], it's too traumatic for the family"…There are some choices that are made for the good of the family and for the status and for the tradition…There were never any divorce in the family…it was just not accepted (participant 20, migrant (migrated for partner)).

Women also spoke about the stigma and loss of status they experienced if they did not comply with expectations of them as women.

My marriage is broke down over there and in my culture it's very bad when you are in this position…A woman have divorce, they just thinking that woman have a fault – that's why. They don't realise that…it's not because of woman. It's because of the man who is…causing problems (participant 12, migrant (migrated for partner)).

In some cases, the marginalisation women experienced because of their gender, and the corresponding inequalities and subordination they faced enabled or perpetuated experiences of abuse.

[The company's clients] felt that they could have me…I was in-between two of the doctors and they both put their hands on my legs. And I was with a colleague…I said 'They're, they're touching me under the table' and he did nothing about it…This male world of abuse…It did have an effect (participant 25, migrant (migrated for better life)).

He hit [me]…he's killing [me], and no one come…[In my country] it's like [your husband] buy you…do nothing, nothing even government, even ward, nothing, and even chief…they also guilty with their wife…[it's] uniform to them, no problem…the man hit to die, no one, even police cannot come (Participant 9, migrant (trafficked)).

Women were also often marginalised and stigmatised after experiencing abuse. Women described the social rejection they faced because of what they had experienced (been subjected to), informed by social expectations relating to their roles or sexuality.

[After one incident of abuse] I didn't go back to my parents, I didn't go to [my husband's] house, I ran away from home…It's a disgrace to the family…so I figured I'm on my own (participant 11, migrant (migrated for asylum)).

He rape me, but after he do that, my culture, I can't turn home. I have to go…he shame me (participant 9, migrant (trafficked)).

6.4.1.1.2 Socio-economic status

Women experienced marginalisation because of their socioeconomic status, including their level of education or training, their employment status, and their financial status. These statuses were often interdependent.

Women described their feelings of marginalisation and in some cases stigmatisation associated with low levels of education or training.

[My friend] is a doctor now…Her mother [said] …'I'm so proud of my daughter and she really done well…that's how all kids should do it'… The more she was saying it I was feeling, "…I've let my mother…myself… people close to me down," cause I hadn't achieved (participant 1, migrant (migrated for asylum)).

Many migrant women spoke about their inability to access education (because of conditions in their countries of origin, cultural expectations (e.g. relating to education for girls or marriage), or the disruption resulting from their migration).

We go field to grow things…nothing else you can do…I never go school before…If you don't go to school and you're illiterate you don't know anything (participant 9, migrant (trafficked)).

Migrant women also talked about how they were unable to pursue training or education once in the UK (for example because of their lack of resources or restrictions (e.g. due to their legal status)). This prevented them from developing or maintaining their knowledge or skills (e.g. their English proficiency or professional skills). Women were also unable to convert or update their previous qualifications or to retrain.

I can't do anything because I'm no recourse to public fund. I want to…improve my…skills, my studies…But I can't do courses, I can't get a certificate…six years waste, for nothing (participant 12, migrant (migrated for partner)).

You don't have papers…You can't go to school, you can't do nothing…English…I can't write it (participant 10, migrant (migrated for asylum)).

Ultimately, these factors informed their employment prospects.

I have no any job…If maybe…I have a good education…I'm going anywhere (participant 22, migrant (migrated for partner/family)).

Women without leave to remain (e.g. asylum seekers) also faced restrictions on their ability to work. They highlighted how they were marginalised through not being allowed to pursue paid employment and the impact this had on their quality of life.

I want to work…Why [can't I] go working?...Asylum: not working, not money, not house, not anything…it is not good life (participant 5, migrant (migrated for asylum)).

Migrant women also spoke about being unable to pursue the jobs they had been trained for or held in their countries of origin (e.g. due to a lack of availability of these positions, a lack of transferability of qualifications, language barriers, or their legal

status), and the marginalisation the consequently experienced because of their resulting deskilling or downward mobility.

I'm graduated, I'm qualify…When you come to this country it's like improve is it? What did I learn? What did I improve? Because normally, I'm a typist…I've done computing and everything (participant 10, migrant (migrated for asylum)).

I just started my one job in a factory. It's very hard…long hours…I was in my country as a cabin crew, so, I work in an airlines. I just want to continue (participant 12, migrant (migrated for partner)).

Both migrant women and women born in the UK described being marginalised and stigmatised because of their (or their partner's) lack of paid employment.

I was just at home with the kids…Some people saw it as I wasn't really doing much anymore, that was the hardest thing for me really (participant 14, born in the UK).

[If] my husband got a big job then people will treat differently (participant 16, migrant (migrated for partner)).

Women also described being marginalised and stigmatised because they received benefits.

Even though we're trying really hard to get work and stuff, we all get judged: "Oh they're always on jobseekers allowance"…It's really stressful (participant 19, born in the UK).

Women also described the marginalisation they experienced because of the barriers and limitations associated with the limited resources they often had in these circumstances.

Living on benefits…it's not a good thing…Baby milk, nappies, clothes…it's really hard…To look for work…You have to do travel…phone calls…Either you're gonna end up going without gas, electric or your rent…or you're gonna have to go without food…Being on jobseekers allowance and living in a council is not what people expect it to be (participant 19, born in the UK).

Many of the migrant women I spoke with had very limited financial resources as a consequence of their migration, including the resources it required to migrate or the barriers to employment in the UK experienced by women or their family members.

I need that Indefinite Leave to Remain…You have no penny, you have nothing…Ten years! People have been working…save their money. What have you done?! Nothing (participant 10, migrant (migrated for asylum)).

Migrant women also described that their financial circumstances were also exacerbated because of a lack of access to resources like financial support (e.g. no access to public funds because of their legal status).

I can't apply for accommodation from the council cause I'm not eligible…you don't have anything…it destroys your mentality; it gives you a low self-esteem (participant 1, migrant (migrated for asylum)).

In some cases the loss of socio-economic status and the financial instability migrant women experienced resulted in limited access to food and clothing, poor housing conditions (including overcrowding, infestation, abusive landlords, or lack of facilities/utilities), and in some cases homelessness. Women described that this had a direct impact on their mental health and well-being.

I'm homeless, it's very, very, very tough and difficult…You can't afford to what you want. You can't like dress properly…I don't eat properly…I can't afford those things, so I'm sick, I'm depressed (participant 10, migrant (migrated for asylum)).

Furthermore, migrant women's lack of financial resources also limited their access to coping resources.

I don't…have a money because I'm no recourse to public fund. I can't go to lot of places like for relax myself…I want to go for exercise…do for some things for to improve my skills, but I can't do it (participant 12, migrant (migrated for partner)).

Women were further marginalised, including being stigmatised and social excluded, because of the downward mobility they faced or their lack of financial resources.

My friend she didn't invite us to her son's wedding…I was shocked…sad…She didn't invite us because we haven't got a good job or a nice house…People, they are looking the status and the class. Not the person only…In [my country] we belong to a high class. And we had got very good friends, high class friends, so in here this is a difference (participant 16, migrant (migrated for partner)).

Socially I think I've lost all those friends…You sort of don't want to look so poor…People…degrade you like in their eyes…cut you out as friends…They don't socialise with you anymore…You can sense the rejection (participant 1, migrant (migrated for asylum)).

6.4.1.1.3 Ethnicity

Women described being marginalised because of their ethnicity, including through stereotyping, racism, and social exclusion. Women's ethnicity often meant they were immediately recognised as a minority and marginalised or 'othered' by the majority community because they weren't perceived to be 'British', regardless of where they (or their parents) had been born.

There weren't any ethnic groups [where we lived]…there was a lot of racism just because we were the first family that was different…I didn't feel British at all, because I felt like I wasn't being accepted…I just didn't feel like I belonged anywhere…I used to

be embarrassed…So you try to hide as much of your cultural background as much as possible (participant 21, born in the UK (second generation)).

This marginalisation also existed at a systemic level. In the education system, for example, the ubiquity of, acceptance of, and failure to address discrimination perpetuated women's marginalisation.

What I found the hardest actually growing up from primary school up till university was the racism…The use of the word 'Paki'… was very common…I changed from one state school to another state school and it was still the same…I was very unhappy…I was really angry (participant 21, born in the UK (second generation)).

Second generation women described that they experienced marginalisation from multiple sources that stemmed from their ethnic background: their own families, their communities (the 'British' majority community and their families' cultural communities), and at a systemic level (for example in the media). The intersection of two cultural or national identities, and feelings of rejection or exclusion from both, resulted in a double marginalisation and a sense of not belonging anywhere.

My mum says to us that we're Westernised…She says it in a bad way…She would like want you to think the way she does…One of them was to do with our own religion…it's now almost portrayed as a bad kind of religion…I remember riding the train, tube the first time [wearing a hijab] and I was thinking, "Oh my God, how will people see me? I mean, will they really look down on me?"…In the media that you hear people are horrible and just call you names (participant 4, born in the UK (second generation)).

6.4.1.1.4 Migrant background

In their narratives, both migrant women and second generation migrant women described being marginalised because of their migrant status and the perception that they weren't 'British' or did not belong in the UK. This was often interconnected with the stereotyping, discrimination, or social exclusion women experienced in the community based on their ethnicity.

They say, "Why don't you go back to where you came from"…You would feel that you've been treated or your parents are being treated differently because they didn't speak completely without an English accent or…they weren't white (participant 21, born in the UK (second generation)).

We feel like a migrant, where we don't belong…People were asking me, "Why are you here?"…They kind of start to accuse you…giving me the sensation to feel…not where [I] belonged…[They] say…"You people are not good." (Participant 6, migrant (migrated for asylum)).

The attitude that migrant women 'shouldn't' be here was often described by women without leave to remain, who felt stigmatised because they did not have 'papers'.

It's embarrassing to be with people, friends, and then tell them, "…I'm illegal in the country"…It's difficult cause people undermine you because they know that…you haven't got that status. Somehow you try not to say it, but at some point they found out…they look at you in a funny way, with disrespect (participant 1, migrant (migrated for asylum)).

Migrant women also described being marginalised because of their language abilities, which also stemmed from the perception of these women as 'outsiders' in the broader 'British' majority community. Women who did not sound 'British' (e.g. due to their accent or fluency) described being stigmatised and facing barriers (e.g. to integrating or work) because of how they were perceived as a consequence of this.

One white woman do the reception [at my work] and because of my English… she's rude to me (participant 27, migrant (migrated for better life)).

I think that one of the greatest frustrations of all of us immigrants has been the language. For example, at the beginning…I cried because I wasn't capable of anything…it is tough, very tough (participant 13, migrant (migrated for asylum)).

English proficiency and literacy presented barriers to engaging in activities like education or work.

It is very difficult to find a job in here...[because of] my English (participant 27, migrant (migrated for better life)).

Language barriers also presented challenges to developing social networks or integrating in the UK, or accessing support from communities in the UK that did not speak women's native language.

I'm no good at speaking. If for sometime I'm really good at speaking maybe I have lots of friend, I share my self side (participant 22, migrant (migrated for partner)).

I to talk to my (English) husband, is quite helpful to me, [but] it's sometimes difficult to explain…That it's a bit stressful, frustrating - I can't say exactly what's happened (participant 27, migrant (migrated for better life)).

A lack of English proficiency also presented other barriers that contributed to women's marginalisation. For example, women described being unable to understand the application forms or information provided to them during the immigration process due to their English proficiency, literacy, or technical knowledge.

The Home Office return [the form] saying that it was the wrong application. I tried to find the right one because I don't know about the law and sometimes it's very

difficult…some words, 'What does it mean? Is it the right form for me?' By the time I sent the second, the right form, it was, refused again because it was over the period of time (participant 8, migrant (migrated for partner)).

Women also talked about the marginalisation they experienced in the immigration system because of the complexity of the system or the lack of information they had been given, and consequently the lack of clarity about what their rights were or what resources they had access to.

[There is] a form…just tick because you can't afford medicine…[But] when you…are asylum…I didn't even sign, I do nothing…Maybe ignorance, because ignorance I didn't [fill the form]…I always buy medicine – that was…very expensive (participant 10, migrant (migrated for asylum)).

I [didn't] know they will help for nursery…It's too much for me to put her in nursery…my wage isn't that…Went back [to my country of origin] with my daughter and I left her there…I was missing her…If I knew I would get help for nursery I wouldn't send her (participant 17, migrant (migrated for better life)).

Women also described feeling that they couldn't utilise resources potentially available to them because they were afraid of the consequences (for example, the impact on their asylum applications if they disclosed health problems, or if they were seen to be using or 'taking advantage' of the systems in the UK).

The owner give me the letter that I have to stop to work until my OCD is recovered. During that and if I go to doctor and psychiatry and if I document everything and do okay they ready to give pay the money, the statuary…doctor give a document…but I don't know – because my visa, first time is I have a just two years of spouse visa and it is not a good idea to claim money, so I didn't (participant 27, migrant (migrated for better life)).

Migrant women (particularly those who had or were currently seeking asylum or had been in the UK 'illegally') also described how stressful and unsympathetic the immigration processes they had been required to go through were because of the extensive paperwork and interviews, intimidating court proceedings, the length of the process, and their insensitive treatment (e.g. by case officers, immigration officials, etc).

When I go to in court, my mind is totally blank…they asking dates, they asking lot of things…I was shocked, I was scared…It's judge in front of me here and another solicitor, here is Home Office solicitor and there's lot of people…it's give me a stressful situation (participant 12, migrant (migrated for partner)).

Look at the Home Office. They are the primary people that should be helping us, and they are not helping us. Who else is going to understand our cases, our situation, to help us?...The way they treated asylum seekers and refugees is something different (participant 2, migrant (migrated for partner)).

Women also talked about the pervasive fear or anxiety they felt because they did not have 'papers' (e.g. while waiting for decisions to be made on asylum applications). For example, women described that they constantly anticipated confrontation with the government or police, and that perhaps they would not be believed or be seen to not belong here. In some cases, this fear persisted even after they had been granted leave to remain.

[I] walk around with fear that maybe a police officer will find me and ask, "Where's your ID?"…And then threaten you…cause I…don't have the papers…When I…hear the sirens, or see anything to do with the law…my heart would go crazy, I would try and hide…I just have the fears that "Oh my God I don't have the right documents"… I think I'll always be constantly anxious about the fact…It's affected my health…I could literally feel physical pain from my heart (participant 1, migrant (migrated for asylum)).

In some cases the fear or anxiety women experienced surrounding their legal status or rights ultimately prevented women from accessing services, or engaging in activities or with the community.

You don't know what will happen to you. You don't have valid document, you don't have right paper…some forms they do ask if you have a refugee status…or to bring as a proof...I was scared, and I have to cancel the appointment. I didn't call them, I didn't go, and I have to stay at home (participant 2, migrant (migrated for partner)).

The length of time immigration processes sometimes took was also marginalising. Many of the asylum seeking or refugee women I spoke with highlighted how long they had uncertain legal status in the UK (e.g. waiting for decisions on their asylum applications, or processes of appealing/making a further submission), and described how stressful these periods were while they did not know if they would be detained, deported, or given leave to remain. Consequently, women described feeling a constant sense of instability and worry about the outcome of their applications.

[The asylum process] was…really hard…it was a trauma…[The Home Office] said, "It's a backlog." And I have to wait and wait and wait…I'm very stressed…I said…"You've been depriving my life for the ten years…that is not a…humane way to treat people…Why you don't respect them? Why don't give them their dignity?" (Participant 1, migrant (migrated for asylum)).

During periods of uncertainty (e.g. waiting for decisions on asylum applications), women also described being unable to settle. Their living situations were often disrupted or changing, they did not know if they would be given leave to remain in the

UK, were unable to be reunited with their families, and ultimately could not develop a sense of place or community.

You just wait til they written your case…When is my turn?!...It's so stressful…you are not settled properly…it's not the life…it's when you have status you bring your family over…I'm so down…I'm like this because I don't have status (participant 10, migrant (migrated for asylum)).

As a consequence women described feeling 'stuck'; this marginalisation was associated with feelings of powerlessness.

If at least I [had] my visa…my life start…These days…I can't do anything…I'm stuck - from four years I'm waste (participant 12, migrant (migrated for partner)).

6.4.1.2 "You're not as free as you want to be" - Disempowerment

Women's experiences of disempowerment were defined by their oppression and limitations on their agency, choice, or control. As the excerpts below show, disempowerment was associated with feelings of anxiety, fear, a loss of self-esteem, and feelings of sadness. Furthermore, it limited women's ability to access coping resources.

I have described women's experiences here as reflecting a process of 'disempowerment' rather than a state of 'powerlessness', as the former denotes a process that is enacted upon women, while the latter describes a static and complete state that is attributed to the individual. This distinction is significant as women's experiences of powerlessness were often the result of their disempowerment by forces at the micro, meso, and macro-level. Furthermore, there were areas in which women retained feelings of agency or control, which characterising women as 'powerless' does not recognise.

6.4.1.2.1 Gender

Women described being disempowered because of socio-cultural expectations or restrictions relating to their gender. Among the migrant and second generation women I spoke with, several had been expected to have arranged marriages, or had been forced into marriages. Women spoke about the impact that their lack of control or choice in these situations had on their mental health and well-being.

I'm scared, because I don't know my [future] husband…no meet, just…wedding day we are met…My parents is really strict…"No you're definitely marry him"…This is my culture, just state who I'm getting married…I have no any choice…Few months I'm really crying and really sad (participant 22, migrant (migrated for partner))

My parents, they were forcing me into…an arranged marriage…It was like I committed a huge crime when I said, "I don't wanna do that" (Participant 3, born in the UK (second generation)).

Women also talked about having no choice to leave a relationship or separate from a partner.

The fact that I couldn't make my own decision and I couldn't move away from the relationship early on, absolutely to do with my gender…Because I was a woman I was not given a choice (participant 20, migrant (migrated for partner)).

Among the migrant women I spoke with, several had been expected to live with their partner's family following their marriage, and described the changes in what was expected of them and increased restrictions on their agency in this situation, and the effects this had on them. They described how socio-cultural expectations dictated where they could go, what they could do (e.g. social interactions, or access to activities or resources outside of the home), what they could wear, and their roles in the household.

My mother-in-law, she is really difficult…strict…I feel sad…She say, "Cover your hair, because not allowed." And that's really difficult…because I'm growing up no always hair scarf…I have nothing choice (participant 22, migrant (migrated for partner)).

Women described that these restrictions of their agency often coincided with abuse (see section 6.3.1, page 195). For example, abuse or threats of abuse were used to control women or to enforce socio-cultural expectations.

I was sold into marriage at the very tender age of 14…I haven't met the guy, I was just told…If I don't agree I'd either be brutalised or forced into it…You're now their possession and they can do what they please with you…the beating started when I…wasn't cooperating (participant 11, migrant (migrated for asylum)).

This disempowerment, enforced through abuse, also limited women's ability to get help. Women described their fear of being exposed to further abuse if the perpetrators found out that they had disclosed the abuse they were experiencing or been in contact with services. Consequently, they felt powerless to seek support resources.

I thought I was going to die [after the forced abortion] …couldn't see a doctor because they would ask you what happened…I couldn't say anything to the doctor because…I would…be killed straight after (participant 11, migrant (migrated for asylum)).

I couldn't even speak up, I was too scared (participant 3, born in the UK (second generation)).

Women's disempowerment in these relationships was often perpetuated because of ways in which they were marginalised as women, for example through socio-cultural practices limiting women's ability to address the situations within which they were disempowered, or to seek support resources.

[Because of the abuse] I went back to my parents' house and it's an embarrassment to do that because you're married. "Why you back here? It's problems", and…they took me back [to my husband] (participant 11, migrant (migrated for asylum)).

Women were also disempowered at the community and systemic level (e.g. by police, health services, or the state) because of the acceptance of or impunity surrounding women's subordination or the perpetration of abuse. The disempowerment imposed at these levels contributed to and perpetuated women's marginalisation, and presented barriers to accessing the resources they needed. Women perceived they had little ability to affect these situations as individuals, and that they had no recourse to address or confront the subordination they experienced.

I would…go to the police station and report [the domestic violence] …They goes, "Ok, we'll deal with it," and never did. Time after time I went to the court house because nothing was done by the police…They goes…"We need a police report, without a police report we can't do anything"…It was always like that (participant 8, migrant (migrated for partner)).

6.4.1.2.2 Socio-economic status

Women were also disempowered because of factors relating to their socio-economic status, including their level of education, their employment status, or their financial resources.

Women described how having limited education contributed to their disempowerment because they perceived the lack of knowledge resulting from it presented barriers to being able to access resources or 'help themselves'.

I never go school before…that was the horrible part…Now I go to school here…I learn…what you can do if this thing happen…If this idea be with me before…I could help myself (participant 9, migrant (trafficked)).

The relationship between knowledge and disempowerment was particularly evident in women's descriptions about how having limited health-related knowledge contributed to their disempowerment in relation to responding to their health needs and accessing services.

I had gestational diabetes…I didn't understand what it was…I wish I knew more, then I would have changed my eating habits and that, cause it would have helped (participant 23, born in the UK).

Women also described the disempowerment they experienced resulting from the limitations their level of education placed on finding paid employment, and their feelings of powerlessness associated with being jobless.

[If I] leave my husband family nobody is look after me, because I don't know good speak English and no good education and I have no any job…if maybe…I have a good education maybe I leave, I'm not suffering (participant 22, migrant (migrated for partner)).

These factors often resulted in a lack of financial resources. Women described that this was disempowering because it made them dependent on others or limited their access to coping resources.

I didn't have my savings…I felt trapped…Because I was relying on him…I think he liked it because he thought "oh now she's completely helpless." (Participant 3, born in the UK (second generation)).

6.4.1.2.3 Ethnicity

Women also talked about situations in which they were disempowered because of their ethnicity. In some cases women described this powerlessness was imposed by their own ethnic communities, often because socio-cultural beliefs, expectations, or norms, which was also often related to other statuses like gender.

[My mum's] daughters couldn't wear trousers in her house…You can't listen to any other music except gospel…I couldn't take part in drama at school because apparently they believed that it's acting and it's telling a lie…We had no choice (participant 23, born in the UK).

Women also discussed barriers to accessing support resources because of socio-cultural factors or expectations within their ethnic group, and consequently their feelings of powerlessness.

He's an Asian doctor…I told him that [my husband] beat me…I need his help, Dr help, but he doesn't give it to me…He refused because he is doctor of him as well…Why don't they equally handle everybody?...He said, "…We know each other by his family and my father know him and he's my uncle" (participant 12, migrant (migrated for partner)).

Women also described feeling disempowered at the community and systemic level because of a lack of accessibility that stemmed from the marginalisation they faced because of their ethnicity, and a lack of understanding about their background or needs.

[I can't] play...volleyball…because most of the places…are not kind of set up for something that's adaptable to my religion…[It's] difficult when you wanted to do something and you can't find a way of doing it…If there's a class, or you have an exam and it's a prayer time when you have to leave the class and pray. Some teachers…don't [let you go] (participant 6, migrant (migrated for asylum)).

As these excerpts show, often the disempowerment women described in relation to their ethnicity was interlinked with their migrant background.

6.4.1.2.4 Migrant background

In the narratives, women talked about their disempowerment in relation to their migrant background. Many migrant women described feeling they had little choice in relation to the decision to migrate. In some cases this was because women's families or partners had decided to migrate, and they were expected to follow.

[I was a] loyal wife – supported him, supported his career. He…wanted to move to the US…so I gave up my job…His next job he got in London…I did not want to come to London at all (participant 20, migrant (migrated for partner)).

Several migrant women talked about how they had been expected (or forced) to migrate to the UK following their marriages or in order to be married, and how they had little choice in that decision because of socio-cultural expectations of them as women (and wives).

I got married and I came here…[I] doesn't want to go to the foreign countries…because the family ties are very strong and my roots are there…every single day I was crying…that was a terrible time for me (participant 16, migrant (migrated for partner)).

Another group of women who often had little choice regarding their migration were the women who sought asylum in the UK. These women had left their countries because of the dangers presented to them by war, violence, or persecution. The trajectory of their migration (e.g. the countries they visited in transit), or their destination was not always within their control, nor was who they travelled with or were able to bring with them.

I left Sudan cause of the war…I didn't know where my mum was, didn't know where my dad was…[I] ran to Uganda…[Then my uncle] managed to bring me here…I came seeking asylum (participant 1, migrant (migrated for asylum)).

Everyone have to run for his life…[the war] get worse day after day and then we had to leave the whole country and migrated…We were happy there and then we have to suddenly move (Participant 6, migrant (migrated for asylum)).

One of the women I spoke with had tried to flee the violence she was experiencing and had ultimately been trafficked to the UK. She described her lack of control over the trajectory of her journey, and her relocation to the UK. Once in the UK, she was enslaved by her traffickers.

[My auntie say], "…This time [her husband] kill her…what can we do for her?"…[Her husband] knew this man, so he come and help me to go make for…passport…I have to go with this man two weeks…They say, "Oh we take you to America"… [Then] I have to go with [two other people] because I don't have any choice…I was thinking it's America…It was this country…They keep me like seven years (participant 9, migrant (trafficked)).

The disempowerment participant 9 experienced with the traffickers was reinforced by her legal status. Because she was 'illegally' in the UK, participant 9 felt she was powerless to escape her traffickers.

They say, "If you go out, police catch you. Never don't talk with anyone." So they keep me…So I was just scared…I think like it's end of my life (participant 9, migrant (trafficked)).

Other women also described the powerlessness they felt in abusive situations because of their legal status. Some migrant women who were dependants described the barriers to escaping oppressive or abusive situations because of the legal consequences, and consequently feeling powerless or 'stuck' because their legal status was dependent on their abusers.

He beat me…I have a immigration problems because…they consider me like I'm a illegal person. Even he bring me over here to get married and his responsibility to give me this right to stay... I try three or four times suicide…because…my husband, then…Home Office…make my life like a football (participant 12, migrant (migrated for partner)).

Women also described being unable to access support resources because of their legal status.

[Because of the domestic violence] I try social, I tried to get hold of this and that, but they didn't help. All they say, "Try to get your status sorted out." I didn't come here to be illegal. I came here, I was married to the guy (participant 8, migrant (migrated for partner)).

In some cases women's legal status was used by others to subordinate them, or prevent them from being able to seek services.

I wasn't even registered with a doctor, I couldn't have medical help…He wouldn't register us…[My husband is] trying to do everything so that I don't get [status]…He not making me legal…I can't understand why the Home Office or the other people didn't see that (participant 8, migrant (migrated for partner)).

[The traffickers] live with me illegally, so I [am not allowed to] go to hospital…Only if I am sick like that Panadol, and if you are sick you have to work…One day I will die in this house, nobody know (participant 9, migrant (trafficked)).

The restrictions women experienced because of their legal status as migrants (e.g. their ability to work, go to school, or travel) also contributed to their feelings of powerlessness or lack of agency.

You can't work…You can't afford what you want…Let us live! (Participant 10, migrant (migrated for asylum).

I still feel like I'm still bondaged…I couldn't go anywhere [as an asylum seeker], literally I was just stuck here… I didn't think that it would take me this long to be free…I didn't think that it would take me this long not to see [my family] again (participant 1, migrant (migrated for asylum)).

Women also spoke about how the complexity of the system and their confusion or lack of knowledge about what their rights were or how to access help was associated with feelings of panic and powerlessness.

I have immigration problem…I struggle…for my solicitor money…So my case is…pending…Where I have to go? It's like a panic and I just want to kill myself again. Because, you know, I don't know the way where I have to go for help (participant 12, migrant (migrated for partner)).

Women also described having little control over or feeling powerless in relation to decisions made about their legal status.

They say they're gonna deport me, I was so down and depress and sick…when you fill that form…they don't want to know more [information about your situation], so you just wait (participant 10, migrant (migrated for asylum)).

6.4.1.3 "You feel alone in the battle" - Isolation

In the narratives women described the salience of isolation, including their separation from their friends or family, and their exclusion from the communities around them. Often isolation was interrelated with women's marginalisation and social exclusion, and was informed by their gender, socio-economic status, ethnicity, and migrant background. As the excerpts show, women described feelings of loss and sadness in relation to their isolation. Furthermore, isolation was associated with a lack of social support, and presented barriers to accessing services.

6.4.1.3.1 Gender

In the narratives, women described how gendered social expectations contributed to and perpetuated their isolation, often in the context of marginalisation or their subordination. Several women described the loss of social networks and isolation they experienced as a consequence of being expected (or forced) to migrate.

I don't want to come here because I hear life is very hard…My husband say you have to come…I can't do anything…it's a lonely life…I still miss home (participant 28, migrant (migrated for partner)).

Women also described being expected to live with their in-laws after they married (either in their countries of origin or after migration). In some cases this resulted in separation and isolation from their families or social networks, which was in some cases reinforced by the expectations or restrictions they faced in their partner's or in-laws' household.

[After we married] we moved to his parents…For months I didn't see outside…I'm not allowed to go…outside without [my husband] …I was really stressed – I used to cry a lot…I don't need much – just go out to see my family, I'm not allowed (participant 17, migrant (migrated for better life)).

There were multiple relationships in which restrictions on women's agency resulted in their isolation. For example, women described becoming isolated because they were required to be accompanied or escorted (e.g. in social situations, or when seeking services), or were limited in who they were able to interact with. These restrictions frequently coincided with feelings of powerlessness or subordination.

He picked me up, he dropped me off…He lived like middle of nowhere, and so I got kind of isolated (participant 15, migrant (migrated for better life)).

In many cases the forms of isolation women were subjected to were abusive, including being confined to where they were living, or restricted in the activities they could engage in (social, education, etc.) or who they could speak to.

He would just keep telling me, "You're not talking to anyone"…I couldn't go out for work…even to the shops…I didn't even come out of the house for four months (participant 3, born in the UK (second generation)).

These restrictions and enforced isolation also limited women's ability to access support resources. Women described being prevented from seeking help, or being unable to access help because they were escorted when engaging with services.

I couldn't say anything [about the domestic violence] to the doctor because obviously [my in-laws] were there (participant 11, migrant (migrated for asylum)).

Women also described they became further isolated, particularly from support resources, because they were threatened with abuse if they did disclose abuse or seek help. In these situations women described being 'stuck' or trapped.

When I do get caught [seeking help], I'll get another beating for that because I've been to speak to people. And I was living in a cell (participant 11, migrant (migrated for asylum)).

Isolation itself was also a barrier to escaping abuse because women had no social resources or support, which enabled or exacerbated women's experiences of abuse.

It was horrible…[But] I didn't know anyone else in London…I didn't have anywhere else to go (participant 3, born in the UK (second generation)).

Women's experiences of abuse also resulted in persisting feelings of fear or anxiety, and a loss of trust. These factors often resulted in women's self-isolation, even after they were out of abusive or controlling situations.

I'm still afraid of people. Even a child, I can get intimidated by a child…the less people I talk to the less I have to be scared…[I'm] in a shell, in a box somewhere, protecting myself (participant 11, migrant (migrated for asylum)).

You're scared…I was really bubbly before…now I just, I don't even feel like mingling with anyone…I don't talk to anyone…I can't talk to men (participant 3, born in the UK (second generation)).

6.4.1.3.2 Socio-economic status

Women described that socio-economic factors contributed to their social exclusion and isolation. For example, in the narratives women described the isolation they experienced because they weren't engaged in education or employment. Women talked about having nothing to do, and also the lack of social networks they had access to because they weren't engaged in work or school.

[If] I'm going work outside, and more physically I'm good. If you're always home…I'm really sad…If I see always going outside I'm not thinking too much (participant 22, migrant (migrated for partner)).

My biggest challenge has been dealing with not having my work… I was just at home with the kids…I think going back to work… people listening to you…there's another side of you that wants…other kind of fulfillment I guess…things to do more to do with the outside world (participant 14, born in the UK).

In some cases women described being unable to engage in these activities, and thus to develop social networks, because of their roles as wives or carers.

I want to do part-time job as teacher because going out is very good sometimes…but because of my husband's health I can't do this...I can't leave him here and going for work (participant 16, migrant (migrated for partner)).

Women also described the isolation they experienced when they were prevented from engaging in these activities, for example in instances of abuse.

Before…I'd see my work colleagues…I had lunch time where I could go out with them…but when I was [in the abusive relationship] I had nothing…I couldn't go out for work (participant 3, born in the UK (second generation)).

Having limited financial resources also contributed to women's isolation. For example, women described being unable to afford transportation, calling cards, or the resources needed to engage in activities that would allow them to develop networks, integrate, or access social resources (e.g. clubs, work, or education). Consequently, women experienced isolation from their social networks as well as social support resources.

The problem is you can't phone, you can't afford the card…to charge your telephone...You can't even go out because…you can't pay your transport (participant 10, migrant (migrated for asylum)).

[In the club I was in] they were talking about stuff I couldn't afford. I couldn't afford to be in, so I quit (participant 1, migrant (migrated for asylum)).

6.4.1.3.3 Ethnicity

The marginalisation many women faced because of their ethnicity often resulted in their social exclusion. For some women, this social exclusion coincided with the loss of friends or an inability to create social networks, which was isolating.

Kids being kids you know they will bully… "You can't come in our house because you're a Paki"…that was really common…I wasn't accepted (participant 21, born in the UK (second generation)).

Women also talked about how social expectations within their families and ethnic communities contributed to their isolation.

My parents weren't the type of socialising…[My mum] was actually born in Pakistan… You can kind of see the difference in the way of their thinking…"Go to school, come home…what's the need of having friends? What's the need of them coming over?" (Participant 4, born in the UK (second generation)).

After I was [forced to get] engaged, it was complete lock down…[My mum] will be like, "You're engaged now, you can't walk around on the streets."…I couldn't be on the phone…I couldn't go out (Participant 3, born in the UK (second generation)).

As these excerpts suggest, the relationship between ethnicity and isolation was in some cases informed by women's migrant status.

6.4.1.3.4 Migrant background

The migrant women I spoke with described the isolation they experienced from their social networks as well as their roots following their emigration from their countries of origin.

I left my mom, my father, and my whole family…now always I'm crying…this country nobody I'm sharing (participant 22, migrant (migrated for partner)).

It's not easy experience to leave the environment where you were born in, grew up, you have friends, relatives, everything around you, just leave it and go and start a new life. It's hard (participant 2, migrant (migrated for partner)).

For many migrant women, their loss of social networks and consequent isolation was exacerbated because of the circumstances of their migration, for example forced migration, a lack of preparation or ability to say goodbye, or the loss of friends or family due to the conditions leading to their flight (e.g. conflict).

I came here…I wasn't with my mother…My father was still back home…There was two sisters and a brother who were missing; we didn't even know where they were (participant 6, migrant (migrated for asylum)).

Women also spoke about the inability to return to their countries of origin and thus a more permanent separation from their social networks.

The war went on and on and on…Things were really bad in Sudan, so when we contacted our relatives in Sudan, they said this, "We advise you not to come [back]" (participant 2, migrant (migrated for partner)).

I want to go back [to my country of origin]…But now it's political conditions…it's not good to live there (participant 16, migrant (migrated for partner)).

Women's separation from those in their countries of origin was also perpetuated by factors in the UK, for example being unable to return home because of financial resources, their legal status, or their obligations in the UK (e.g. carer roles), or the inability of friends or family to visit them in the UK (e.g. due to visa restrictions).

My back home is really expensive for ticket…I'm not going, because of money problem…I'm really sad…It's problem again [to bring my mother here], because she has no any visa (participant 22, migrant (migrated for partner)).

One day I want to go back…But my children, who were born and grew up in UK, it's hard for them to leave…I find it really hard and I don't want to spend the rest of my life here. I want to go back to my friends, to my people…[It's] something I have to think of – whether I will go, leave the children (participant 2, migrant (migrated for partner)).

There were other factors related to women's migrant background that further contributed to their isolation. Women described the isolation and loneliness they experienced because of the challenges they faced developing social networks or integrating in the UK, or being able to share with others because of their English proficiency.

I have no one…you are alone...because you can't express yourself properly…you have limit (participant 10, migrant (migrated for asylum)).

Women, particularly those without leave to remain, also described how their fears relating to their legal status and their right to be in the UK resulted in their self-isolation.

You don't have anything to show that you are legal in this country...[If] the police stop you, they ask you, and you don't have anything to show them, they will think that you are illegal…So I was like in hide…stay at home (participant 2, migrant (migrated for partner)).

6.4.1.4 "This gave me strength" – Coping processes

Women's coping processes were defined by the resources and strategies they utilised to respond to the stressors they were confronted by throughout their life course (e.g. prior to/in anticipation of stressors, whilst stressors are being experienced, and following stressors or in relation to changes in their mental health and well-being). These coping processes were fluid, as the resources women needed or their coping strategies changed according to their circumstances (for example the stressors they were experiencing, what resources they had available to them, or their health status).

In the narratives I identified two sub-themes that were salient elements of the coping processes women spoke about in their interviews: coping resources and empowerment. These coping processes enabled women to manage the impact of stressors on their mental health and well-being, and were perceived to have a positive effect or to reduce their stress, even if this effect was only temporary.

6.4.1.4.1 Coping resources

The resources women felt had helped them to cope with stressors over their life course included their individual characteristics, coping strategies, and support resources.

6.4.1.4.1.1 Individual characteristics

In the narratives women talked about personal characteristics they felt had helped them to cope with stressors, including their strength, intelligence, hardiness, or confidence. In the narratives, it was primarily migrant women who talked about these positive aspects of themselves.

I am quite intelligent…I'm always pull through…I'm quite confident and I have got very strong personality and no one is going to mess my life up…I have a brave heart (participant 18, migrant (migrated for a better life)).

Women talked about how their sense of self-worth or recognition of their own value helped them to cope or motivated them to keep going.

I made several attempts to take my own life. I had to stop because something just struck me. "Why? Why am I hurting myself when I've been hurt so much by other people?"...I said, "...I'm not gonna do that (participant 11, migrant (migrated for asylum)).

There was a one voice saying, "No, you can't [die], you try, you hard, you still living, look where you come from, you're still here" (participant 9, migrant (trafficked)).

Women's roles or accomplishments (for example relating to education or their careers) were also an important part of their identity. Women described the importance of being able to pursue these goals, which made them feel capable, contributed to their self-worth, and made them feel that their life had meaning or value.

[Going to university] was my own achievement…I was doing it not to prove to anyone else, but to prove to myself I can achieve something, I can become something (participant 4, born in the UK (second generation)).

I enrolled in a college…I did…"Association of Accounting Technician," because in [my country of origin] I study accounting. So I just found myself. I become useful again, and I'm doing something good for myself, rather than staying at home (participant 2, migrant (migrated for partner)).

Women's responsibilities, for example as a mother or carer, were also significant roles that women described helped them to cope and motivated them to keep going.

Being a mum is all about like going to the limits with the kids and obviously you have to be strong enough to want to help them and not just give up (participant 19, born in the UK).

I said, "…I can't stay down. Life continues. I have children."…And this gave me strength…I was motivated; it's auto-esteem... [My children] have very much been my motor (participant 13, migrant (migrated for asylum)).

Women also described that feeling like they were contributing to others or needed by them contributed to their sense of mattering and made them feel good.

Women also described that feeling like they were contributing to others or needed by them contributed to their sense of mattering or made them feel good.

Good thing is I someone need me…Children [where I work] really need me, so it's feel very good (participant 27, migrant (migrated for better life)).

6.4.1.4.1.2 Coping strategies

In the narratives women also talked about the coping strategies they utilised to manage stressors. For example, women described activities they could engage in that made them feel better, including work or education, exercise, crying, good food, reading a good book, writing, or watching a film. These activities did not necessarily change the situations they were in, but they were perceived to provide women comfort or a temporary escape that helped them to face things.

I use to be much more temperamental and would throw tantrums or just lose it... But when I started to run and jog…I was a different person…It changes everything (participant 25, migrant (migrated for a better life)).

Often women described that the benefit of engaging in these activities stemmed from keeping busy or getting out. Women described that being active or finding distractions were important strategies to avoid being inundated by their thoughts or sadness or 'thinking too much', particularly when they were isolated.

I wanted to be busy…Because if I have a spare time, then…I was thinking about what happened…and I didn't want that to happen. So I was always trying to make busy myself, keep it busy (participant 6, migrant (migrated for asylum)).

Women also spoke about activities they engaged in that made them feel better, but that they didn't view as positive strategies, or which in some cases had a detrimental effect. These included drinking, smoking, or self-harm.

The worst thing…bad behaviour…I'll need a cigarette…just to give me thinking time. My life is hard (participant 8, migrant (migrated for partner)).

I would cut myself…because it just made me feel better…Because it hurts so much you don't think about it anymore (participant 3, born in the UK (second generation)).

Another strategy women spoke about was moving on with one's life, ignoring stressors, focusing on the future, or putting events into context to help them cope with stressful situations.

I've just sort of adopted the attitude, "Well you just got to get up and get on with it…there's no point in sitting feeling sorry for myself. That won't do me any good and it won't do anybody else any good" (participant 26, born in the UK).

It's the only way I can live is just to concentrate on the future…You can't change the past, but you can change what is coming. You can make it better in the future, if you want it (participant 6, migrant (migrated for asylum)).

Women also talked about how their aspirations for the future, which were often focused on the pursuit of goals within these areas, motivated them to go forward.

What are your goals looking forward?

Working. Giving my kids everything that I never had. Achieving in my life…That would be my achievement is to be working and to make sure my kids are happy (participant 19, born in the UK).

Women also described that helping others (e.g. because of their own experiences and knowledge) was another coping strategy that motivated them to go forward and helped them to cope.

I would like one day…to go change some women in my community to tell them, "Women you are not rubbish!" That's why sometime I'm still living. Sometime I feel like dying, but I have to voice this voice that it's want say, it's want to shout, "…You can't die until you do something!" (Participant 9, migrant (trafficked)).

Women also talked about how being optimistic and having hope helped them to cope.

Having hope is the most important thing (participant 6, migrant (migrated for asylum)).

I am really an optimist…I think that when one is low…you breathe and say, "I am going to do this, I am going to get out"…I think that it has helped me…a lot (participant 13, migrant (migrated for asylum)).

Women's hope or optimism was often spoken about in the context of their belief systems. Women described that their faith or spirituality helped them to cope or get through difficult experiences, and that their relationships with God (or other entities) were an important source of support.

I kind of became religious…I started having more belief, because if I didn't have that then I would find every day quite hard (participant 21, born in the UK (second generation)).

I can't stay without a God… that give me strength…to live…that's the thing only I have, nothing else I have, and He keep fighting for me…God sometime pull me out of danger (participant 9, migrant (trafficked)).

6.4.1.4.1.3 Support resources

In the narratives, women highlighted the importance of social support, including both emotional support and instrumental support. Women also spoke about the support (or lack of support) they had received from services.

Women described that emotional support helped them to cope because it made them feel loved or cared for, and secure and confident.

My partner…makes me feel so secure and confident…gives me that complete backing…when I go into battle. That's been the biggest…positive thing in my life…he's there just completely supporting me (participant 25, migrant (migrated for a better life)).

I find it really hard unless I phone my friend, and I speak to her, and she support me, and then I manage (participant 2, migrant (migrated for partner)).

Women described that an important aspect of emotional support was having someone with whom they could talk about their experiences.

Really close friends…we did talk about everything…that's a big support for me (participant 14, born in the UK).

Telling [my friend] about my story…the suffering, and all what I've been through, I think that managed to give me a relief…I found myself feeling a bit lighter, because that one was holding me and I feel heavy (participant 2, migrant (migrated for partner)).

'Connecting with loved ones' was highlighted as an important source of emotional support, particular for the migrant women I spoke with. However, for many migrant women, connecting with loved ones was difficult (because of legal issues, financial resources, or conditions in their country of origin). These women described that this made it even more valuable when it could occur.

[It was] impossible for me to see my Mum…and when she told me that she got the visa…it was really something I really keep my mind up, whenever I remember that day, it's the happiness (participant 6, migrant (migrated for asylum)).

I just managed to travel…and I met a lot of relatives, friends…people whom I knew from [my country]. And I felt like I was been born again (participant 2, migrant (migrated for partner)).

Faith communities were another important source of support women described.

I found a church…Morally they are really helpful…They encourage you…"You're not the only one going through this," and "Just keep praying, just keep believing" (participant 1, migrant (migrated for asylum)).

The women I spoke with also talked about how other women were also an important source of emotional support.

There are maybe in your life…a lady like who's older than you…maybe if in situations you got a problem…you find favour in their eyes…that's been really like the highlights of my life…it's been very encouraging (participant 1, migrant (migrated for asylum)).

I'm glad [my aunty] was there cause I tell her everything. She's like she's my mum (participant 23, born in the UK).

Women also spoke about the support they received from people who had been through similar experiences, and the benefit of solidarity or empathy.

[My aunty and I] both understood each other what was going through…It affected us both so we started talking to each other (participant 23, born in the UK).

With the ladies [from my country of origin] …we can talk…about what happened in the past, and then we were lucky to survive it and come here…It's just for our own way to deal with it…When we talk about it, I feel that the things that accumulated within me are start to get less and less (participant 2, migrant (migrated for partner)).

In the narratives women also described that a lack of access to emotional support compromised their ability to cope, and negatively impacted on their mental health and well-being. Women highlighted the significance of not having anyone to talk to, to provide companionship, or to make them feel loved or cared for, and the feelings of sadness, being alone, loss, and meaninglessness that accompanied this.

I wish my mom was there… I was heartbroken…I just wanted somebody to listen…to encourage you when you're so down, and you can just put your head on her lap…And she would just say, "Oh my child, you'll be fine"…Somebody that you know that they actually…genuinely care about you and they'll always forever care (participant 1, migrant (migrated for asylum)).

Women also described being unable to benefit from emotional support because they couldn't talk about their experiences. In some cases, women described that it was too painful or sad to talk about what had happened to them, or that revisiting events negatively impacted on their health or well-being. This resulted in women's self-isolation, and presented barriers to utilising social support resources or services.

[When] I talk about [my experiences], I become sick…they're coming like I remember them again (participant 9, migrant (trafficked)).

When I go into details I can't help but cry…I didn't really talk to anyone (participant 3, born in the UK (second generation)).

Women also described being unable to talk about or disclose their experiences because they were afraid of being marginalised or stigmatised.

I used to keep everything in to myself because I didn't know who to talk to…what they will see me as, or what they will think of me (participant 4, born in the UK (second generation)).

I'm not 100% open with any of [my friends]……they'll pass funny comments…their countenance changes…and I have to draw back, and I have to go back into a shell (participant 1, migrant (migrated for asylum)).

Women described that, instead of talking about things, they often hid what was wrong or pretended that everything was alright.

[You] try and put a façade being that you're fine…and sometimes that's even more energy to try and pretend (participant 21, born in the UK (second generation)).

I'm pretend…All the time I hide…I don't want them to see negative…I smile, even I'm sick…Nobody can know (participant 9, migrant (trafficked)).

Another type of social support that women described was a valuable coping resource was instrumental support, for example access to financial support, accommodation, childcare, assistance in an emergency, or help accessing services.

We moved here and there's a big support group in the estate. Everyone knows everyone so if anyone needs help everyone's [snaps fingers] (participant 19, born in the UK).

When I'm sick…[my mother] is just coming and visit me…She is always help me cook, tidy upping…she manage whole of my kids and my family…nobody helps more than my mom (participant 22, migrant (migrated for partner)).

In particular, several migrant women described how important the instrumental support they received as new migrants had been for helping them to cope (e.g. from new contacts or family members already in the UK).

I was lucky I had two brothers over here…One, he was working and he did help me to come over here…As soon as I came they find me a job (participant 18, migrant (migrated for better life)).

[People] in church…and Sudanese people…helped me carry on a lot, especially like financial wise…they'll help me for transportation, and food or whatever – little things, pads and stuff that you need as a girl (participant 1, migrant (migrated for asylum)).

However, many of the migrant women I spoke with had limited social networks in the UK (e.g. due to their separation from their existing social networks, and a lack of new networks in the UK). Consequently, it was often difficult to access instrumental support.

It's hard and especially when you come to a place like England…Because [in my country of origin] if you need anything you can just pop in to your neighbour…Here unless the neighbour knows you well, then they will be allowing you…When I came…I know nobody (participant 2, migrant (migrated for partner)).

Women described that a lack of instrumental support contributed to their financial insecurity, and presented barriers to accessing services.

If I say I need £1, [people] won't give it to me…If I need help, people don't help me, they say I don't need nothing (participant 10, migrant (migrated for asylum)).

I couldn't get the support I needed so I was alone…my finances were pretty poor and it as absolutely horrendous (participant 15, migrant (migrated for a better life)).

A lack of instrumental support also resulted in women's inability to escape situations like abuse. Women described having nowhere to go and no way to access resources, which contributed to their feelings of powerlessness and being 'stuck' or 'trapped'.

I ran away [from my abusive partner]…I was on the streets living for some time…nobody's there to help me to protect me in any way at all (participant 11, migrant (migrated for asylum)).

In addition to these forms of support, women also spoke about the support they had received from services, including social services and health services.

There have been social workers that are very good that have been with me shoulder to shoulder…good doctors…always the people helping me (participant 13, migrant (migrated for asylum))

My key worker, she's been really helpful… She just put a lot of things into perspective for me (participant 3, born in the UK (second generation)).

However, women also spoke about instances in which their contact with services was not perceived to have been helpful, and in some cases was seen to be detrimental.

[My psychiatrist] was a nasty piece of work. He was horrible. He was rude…He was so cold…He was not a nice person (participant 24, born in the UK).

I said to the doctor about [my symptoms], and he said, 'Oh I don't know [what it is].'…[Years later] I read in a magazine and somebody had written in to a doctor and describing exactly what I had…I said to him this is what I've got, which if it had been caught early enough…would have been curable…He said, 'Oh yes you have [that].' I felt like saying arghhh! (Participant 30, born in the UK).

6.4.1.4.2 Empowerment

In the narratives, women spoke about strategies that were empowering or that they perceived gave them strength and enabled them to address or cope with stressors. Forms of empowerment women described included 'action', 'resistance', and 'independence'.

6.4.1.4.2.1 Action

Taking action was a proactive strategy women described for addressing stressors, and was empowering because it gave women a sense of agency. Women described the significance of both what they were able to achieve or access through their action, and the sense of power, strength, or control, or they felt through actively doing something to manage stressful situations. They also described the determination and strength this often requires (see discussion on individual characteristics, section 6.4.1.4.1.1, page 230).

I just said: "Enough is enough"…"This is not what I want in my life"…I'm strong character…I decided that…I wasn't going to allow all of this…and so then gender or no gender made difference, as I just went ahead and did what I had to do (participant 20, migrant (migrated for partner)).

Attaining knowledge was a form of action that women described to be enabling and empowering. This was because of the sense of accomplishment or feeling capable women experienced, and because acquiring knowledge enabled them to overcome many of the barriers they faced (for example due to language, their skills or level of education, or lack of knowledge about health or services).

I'd never heard of [autism]… [When my son was] diagnosed with autism I was like my God. But then actually, I was doing more research on it…[I] learnt how to obviously calm him down and talk to him and get his attention…I know how to deal with it (participant, 19 born in the UK).

It was tough…because, well, I didn't speak much English…I studied, I learned…I am [now] capable of English…I am capable…If [my children] need to go to the hospital I do it, many things (participant 13, migrant (migrated for asylum)).

Women also talked about learning from their experiences. This knowledge was also seen to be empowering or to help them to cope with stressors later on.

For me it was a very learning experience. Because what didn't kill me made me stronger (participant 8, migrant (migrated for partner)).

I was kinda like glad I went through all that cause then it kinda set me up…I'll know exactly what to do and what not to do and how to go about things because I've been through it (participant 23, born in the UK).

6.4.1.4.2.2 Resistance

In the narratives women also described the importance of 'resistance' as a strategy for challenging or confronting stressors, and the empowerment they experienced through this expression of their agency. 'Resistance' was salient because by resisting or taking things into their own hands they gained control or reduced their sense of powerlessness.

There was one time [when I was pregnant] he kept pushing me, pushing me, pushing me…he was going to hit me, I just…pull my hand back and just swing and really I burst his lip and he was shocked and then I told him…"Next time you lay hand on me I'm going to call the police. I don't care if I get deported I'm going to call the police." And from there to the giving birth everything went fine, he left me alone (participant 8, migrant (migrated for partner)).

I am a mother who really fights. A mother with a lot of desire and a lot of strength…I am capable of fighting, of defending (participant 13, migrant (migrated for asylum)).

'Seeking justice' and 'speaking out' were specific forms of resistance through which women confronted unjust situations or imbalances of power.

We've tried to take [the Council] to court to sue them for how we were treated…we were taken into care for our care and protection!…When it's finished I reckon it'd take ten years off me…to say, "No this is wrong you can't treat people like this" (participant 24, born in the UK).

I don't know if [playing tricks] was a way at getting back…but I use it as a thing for me not to be humiliated on a daily basis. It kind of built up my self-esteem (participant 8, migrant (migrated for partner)).

I have to kind of answer back…having my own views and my own thoughts and having them heard…speaking out (participant 4, born in the UK (second generation)).

Sometimes women described that these strategies not only helped them to improve their current situations, but also had a benefit for women collectively.

Lot of woman suffering because they can't speak, and I'm speaking (participant 12, migrant (migrated for partner)).

Migrant women spoke about strategies of resistance more frequently in the interviews than women born in the UK, which may be attributed to their limited social support, restrictions on their rights or resources because of their legal status, experiences of marginalisation because of their ethnicity or migrant background, or the impunity or acceptance of events like abuse in their countries of origin or communities.

[They] do nothing, nothing even government…That's why in future I would like to write a story to talk about things I face…[women in my country of origin] don't know any other ways…know only if you suffer too much only death can help you, nothing else. And no one ever go to tell them, "You can do this, you can do that to help you." So I'm saying (participant 9, migrant (trafficked)).

I said, "…I need to show [the Home Office] that I am not happy"… So I just went and take a paper and pen and I write everything that's bothering me…and I fax it to them… Sometimes I write four pages, three pages…I fax and I fax and I fax…I think they knew…I'm not happy the way they are treating me…It was in less than two weeks I received a letter from them saying…that I was given indefinite leave to remain (participant 2, migrant (migrated for partner)).

6.4.1.4.2.3 Independence

Women also described that seeking or asserting their independence was also an empowering coping strategy. 'Independence' was often the result of 'action' or 'resistance', and was particularly salient for women who regained their independence (e.g. after experiences like abuse or subordination). In the narratives, women described that independence made them feel capable, in control, and free. Furthermore, it helped enable them to access support resources.

You'd like to be independent and do stuff for yourself and, and be strong (participant 1, migrant (migrated for asylum)).

When I came to [the organisation] …I was so happy…they gave me a key and told me I could come and go as I pleased…all I want is to be is independent. There is nothing that I want more (participant 3, born in the UK (second generation)).

When I gave up my marriage…I [could] just do anything…focus on myself and my priorities…I suddenly discovered…the possibilities of life…I just wasted so much time with someone else's time…it was not life to the fullest (participant 20, migrant (migrated for partner)).

6.4.2 Conceptualisations of mental health and well-being

In the interviews, women spoke about the relationship between these four processes, the significant events they had experienced, and their mental health and well-being. How women talked about their mental health and well-being was informed by their lived experience, and varied because of the diversity in their characteristics, their exposure to these processes or significant events, and the current context.

Here I describe women's conceptualisations of their mental health and well-being over their life course in relation to their 'emotional health' and their 'whole body'.

6.4.2.1 Emotional health

Women's conceptualisations of their emotional health pertained to feelings of anxiety, feeling sad or down, and cognitive disruption.

When women spoke about emotional responses to their experiences they often did not use psychiatric terms to describe these feelings, and instead described their emotions in terms of their frustration, anger, sadness, guilt, hopelessness, irritability, worry, fear, or stress. Where psychiatric terminology was used, 'depression' was used most frequently. In some cases women applied psychiatric terms themselves to describe their emotional health, and in other cases they had been given these diagnoses by health professionals. These terms were predominantly used by women born in the UK, or migrant women who had exposure to 'Western' health systems. These women were either born in countries where these health models were dominant, had been in contact with services here in the UK, or had been in the UK for a longer duration.

I feel very depressed and also the OCD become worse…And there that time I first go to doctor (participant 27, migrant (migrated for better life)).

The depression did hurt me bad, it did…I even went on anti-depressants as well for a while…I went to the GP and I just told them what I was experiencing and they just described anti-depressants (participant 23, born in the UK).

Below I will describe how women talked about feelings of anxiety, feeling sad or down, and cognitive disruption.

6.4.2.1.1 Feelings of anxiety

Feelings of anxiety were described in nearly all of the interviews. Women described feeling stressed, being unable to sleep and having nightmares, having their mind rushing, fearfulness, nervousness, paranoia, anger, being unable to escape their thoughts or to relax, and feeling like they were re-experiencing stressors.

I couldn't sleep at night, I kept having really really bad nightmares…I can't relax anywhere, I always have to be on my guard (participant 3, born in the UK (second generation)).

I get stressed…I freeze…I can't do much…but my mind is rushing so fast, and thinking, and worried (participant 1, migrant (migrated for asylum)).

In my memory it's coming…they come like boomp…I feel like I can't breathe…it's like it's happening real (participant 9, migrant (trafficked)).

I know it's in my head, but I would feel someone's looking at me. I would hear noises, I would hear keys…shoes…I would be sleeping…and then it's like someone shock me, I would just jump. Really scary (participant 11, migrant (migrated for asylum)).

Many women talked about how their anxiety worsened with an accumulation of stress (either over an extended period of time, or multiple stressors experienced simultaneously), or when they could not reduce these levels of stress, for example because of limited coping resources. This was particularly present in the narratives of the migrant women who talked about the quantity of stressors they felt they were experiencing during the process of settling in the UK.

It's like, you know, when you are filling with the water and it's full of water?...My life is like this…From refuges, from Home Office, from husband…they give me pressure, lot of pressure…I'm fed up from everything and it's too hard…it's because of these my mentally stress (participant 12, migrant (migrated for partner)).

6.4.2.1.2 Feeling sad or down

Periods of feeling sad or down were frequently spoken about in the interviews. Women described feeling 'depressed', crying, grief, a sense of meaninglessness, not being able to do anything, and sleeplessness.

Grief is very hard…it occupies your mind a lot and…it changes your mood (participant 21, born in the UK (second generation)).

I got this huge sense of meaninglessness, complete pointless…I didn't want to do anything (participant 15, migrant (migrated for better life)).

I was sad…crying crying all the time…the way I cry in my life I think is tears...to never come to my eyes again, and they're still coming (participant 9, migrant (trafficked)).

I forgot how to smile. It was a very sad time for me (participant 13, migrant (migrated for asylum)).

I did actually go through post-natal depression…I loved [my baby daughter] to bits, but I just felt different, it felt weird…[I] struggled sometimes…sleepless nights…depression, everything took over (participant 23, born in the UK).

Several of the migrant women I spoke with conceptualised their experience of feeling or sad or down in terms of 'thinking too much'.

I'm really, you know, physically sad. And if you have lots of thinking look like I am depression (participant 22, migrant (migrated for partner)).

Thinking too much…all things come together…I feel like I think like it's end of my life (participant 9, migrant (trafficked)).

Women also talked how feeling sad or down made them feel like they 'just wanted to die'. Among the women I spoke with, migrant women and second generation spoke most frequently about having suicidal thoughts or attempts at suicide.

I took, you know Paracetamol pills…I really didn't want to wake up…I just wanted it all to go away (participant 3, born in the UK (second generation)).

I'm suffering from six years and nothing help me with my life…I was in hospital because I tried to suicide myself…just finish my life because I'm thinking after my…life ended things are going better (participant 12, migrant (migrated for partner)).

6.4.2.1.3 Cognitive disruption

In the narratives women also described experiencing cognitive disruption, including confusion, memory loss, and forgetfulness. Only a couple of the women born in the UK talked about this, and they described not being able to remember what had happened, blocking out a memory, or having a blank spot in their memory.

I remember meeting [my foster parents], but I don't remember anything else from there…it's like blank. It's like it's not there (participant 19, born in the UK).

Sometimes women intimated they thought these blanks spots might be surrounding stressful or traumatic events (e.g. abuse).

When I was in [care]…I was battered…we were starved…[others] were sexually abused…I don't know [if I was]…[The doctor] said I could have blocked it out…I read in the records that he the father, social services thought that he abused his own two daughters and yet they sent me there…It was horrible (participant 24, born in the UK).

Cognitive disruption was more commonly spoken about by migrant women. Most often they described experiencing cognitive disruption in combination with other feelings (e.g. feelings of anxiety or sadness). Several described memory loss or having a blank spot, which was often associated with stress or anxiety.

It's a lot of stress…things are vanish because it's lot of stuff on my mind…[I] have a [court] hearing…it's give me a stressful situation so my mind is totally blank…I don't remember what you're asking me and what I said to you. It's like this my mentally situation (participant 12, migrant (migrated for partner)).

Another form of cognitive disruption women described related to their cognitive functioning and the disruption they experienced in their day to day life.

Depression, it was too much…my mental health it become – I'm confused. I can't cook. If I put something in the fire…I don't think is I put something in the fire, so later…when I go it's all smoke…burning…I don't cook because of that, I'm still forgetting things because it's too much for me (participant 9, migrant (trafficked)).

6.4.2.2 My whole body

In the narratives women described an interrelationship between their emotional or mental health and an embodied or physical experience of their health. The theme *my whole body* describes this conceptualisation, including changes women described in their body and functioning, and their embodied experience of their mental health and well-being.

6.4.2.2.1 Changes in body and functioning

In the narratives women discussed physical changes that they perceived to be related to their emotional health. This included changes in their bodies, for example gaining or losing weight, bad skin, greying hair, or allergies.

[I] was actually very stressed, so I would get almost like asthma…hay fever…I think stress has a lot to do with the allergy syndrome…I put on weight and then hair became…greyed…physical manifestations of the stress (participant 20, migrant (migrated for partner)).

I get spots when I'm stressed out (participant 1, migrant (migrated for asylum)).

Lost weight as well…I was like size fourteen…but then going through all of that…I'm down to a size eight now (participant 23, born in the UK).

Women also spoke about changes in their physical functioning, including a change in appetite, fatigue, weakness, or being unable to get out of bed.

I was in shock [when my nephew passed away] and then I couldn't look after [my son] for about a month…I couldn't get out of bed…I just couldn't function (participant 21, born in the UK (second generation)).

I was so stressed out…I couldn't walk…I got dizzy…I didn't do much (participant 15, migrant (migrated for a better life)).

6.4.2.2.2 Embodied experience of mental health and well-being

The effects of women's experiences on their 'whole body' were not limited to these changes in body and functioning. In the narratives, women (particularly migrant women) used descriptions of an embodied experience of their mental health and well-being. This was often verbalised in terms of physical sensations or 'symptoms'.

In some cases women talked about physical symptoms that they attributed to their mental or emotional health, or used physical symptoms to describe the changes they

perceived in their mental or emotional health. In these cases women seemed to make a distinction between physical and mental health.

[Being constantly anxious] has affected my health…I could literally feel physical pain from my heart…very sharp pains, like needle pains, like constantly in my heart (participant 1, migrant (migrated for asylum)).

When I start thinking about problem, I have neck problem also, it start paining me badly (participant 10, migrant (migrated for asylum)).

However, sometimes when talking about their mental health and well-being, women did not distinguish between physical or emotional health or symptoms (which was distinct from the dichotomisation of body and mind in the Western health model); instead, women spoke about their mental health and well-being in relation to their 'whole body'. Women described their experiences of their health through 'embodied metaphors', for example speaking about pain, pressure, or heat.

The pain I have in deep inside me…my heart is pulled apart…cry, sick…hot, all my head is hot, and I feel like I'm burning (participant 9, migrant (trafficked)).

I am depressing…I have burn heart…I have a lot of thing like my head is so – like yesterday I was so down, it's hot, very hot…It's because of the situation - affect my health…heart is hot…Now I [feel] it all, this thing make pressure. I feel hot (participant 10, migrant (migrated for asylum)).

Among the migrant women, this was sometimes talked about in the context of 'thinking too much' (also see conceptualisations of feeling sad or down, section 6.4.2.1.2, page 241).

The tears coming…I feel sick…I know when I'm sick I take medication…it's keeping you not to think too much (participant 9, migrant (trafficked)).

In this chapter, the stressful life events women perceived to impact on their mental health and well-being, processes informing how women's mental health and well-being were affected, and women's conceptualisations of their mental health and well-being were presented. In the next chapter I will discuss these findings and their implications for research and practice.

Chapter 7: Qualitative study of the mental health and well-being of migrant women and women born in the UK: Discussion

7.1 Main findings

This study investigated experiences perceived to impact on women's mental health and well-being through in-depth qualitative interviews with a purposive sample of 20 migrant women and 10 women born in the UK living in London.

Women described a range of stressful life events they perceived had a negative impact on their mental health and well-being, which they conceptualised in diverse ways, including in relation to their emotional health and their 'whole body'. Abuse was perceived to be particularly detrimental, and was endemic among migrant women and women born in the UK. I identified processes of marginalisation, disempowerment, and isolation, which contributed to women's exposure to stressful life events, had an adverse effect on their mental health and well-being, and presented barriers to accessing resources. In the narratives, women also described coping processes which enabled them to address stressors and their effects.

7.1.1 Stressful life events

The stressful life events women perceived had impacted on their mental health and well-being included abuse, witnessing violence, stressful events relating to close relationships, and physical health events. These events have been identified to increase the risk of psychological symptoms in previous research [243, 365, 490, 491].

This study contributes to existing research by situating women's exposure to these events in relation to other experiences (e.g. other stressful events or processes of marginalisation, disempowerment, and isolation) and in a temporal context (e.g. prior to, during, or following migration), which demonstrated that the stressors women experienced were often concurrent, interrelated, or chronic. Furthermore, the changes women described in their mental health and well-being were often not attributed to an isolated event. The concept of 'stress proliferation', which suggests that stressors may not be independent, resulting in the clustering of stressors or chronic strain, seems pertinent here [492]. The findings also illustrate the interrelationship between the stressful

life events and social stressors experienced by migrant women and women born in the UK, and how they compromise access to services for and the mental health and well-being of these two groups.

Abuse, in particular, was perceived to have direct detrimental effects on women's mental health and well-being. The abusive experiences women disclosed included psychological or emotional abuse, physical violence, sexual abuse, and exposure to unhealthy living conditions. Many women experienced multiple types of abuse over their lifetime, often simultaneously, which is supported by research showing that multiple forms of abuse (e.g. physical and sexual) are often experienced simultaneously [367]. The disclosure of abuse by both migrant women and women born in the UK illustrated that these experiences are endemic across diverse groups of women, and are present in 'majority' as well as 'minority' or migrant communities [244, 442, 470].

The prominence of experiences of abuse may reflect the sampling frame I used. Women were recruited from the SELCoH Study (a high rate of exposure to stressful life events, including abuse, was identified among women in the cross-sectional survey, see chapter 3, section 3.4.4.2, page 109), and community organisations which focused on providing services to women who may be at increased risk of or who had previously experienced abuse (see chapter 5, section 5.3.3.2.1, page 173). However, underreporting is common in sensitive research [489, 493, 494], so even more women in the sample than described here may have experienced abuse which they chose not to disclose.

7.1.2 Processes

Women's exposure to stressful events, like abuse, and the impact of these events on their mental health and well-being were informed by processes of marginalisation, disempowerment, and isolation, and women's access to coping resources. The findings contribute to the literature by contextualising women's exposure to stressful events and changes in their mental health and well-being in relation to these processes over the life course, rather than looking at them as independent events. Furthermore, the findings contribute to the current literature by examining the structural factors impacting on women's mental health, rather than solely investigating the relationship between individual characteristics, exposure to stressors, and resulting psychological symptoms.

7.1.2.1 "I'm outside of world" - Marginalisation

Marginalisation was perceived to contribute to changes in women's mental health and well-being because of the social exclusion and oppression that resulted from it and the barriers it presented to accessing health services and social support. Women were marginalised at the micro, meso, and macro-levels. The processes of marginalisation identified in the narratives resulted in women's social exclusion[495] because of their gender, socio-economic status, ethnicity, and migrant status. These statuses informed women's social location and contributed to a process of social exclusion from the social systems surrounding them, including rights, citizenship, participation (economic, political, social, or cultural), resources or services, and community (geographically or socially).

In some cases the statuses for which women were marginalised intersected, resulting in 'multiple marginalisation'. This reflects the concept of intersectionality [229, 232, 442], in which women's identity, experiences, and social location are not determined by one isolatable characteristic (e.g. ethnicity), but rather the multiple characteristics or groups they identify with, and the resulting diversity both across and within categories (e.g. as designated according to gender, ethnicity, etc.). The experiences of multiple marginalisation and intersectionality identified in this study is also reflected in discourses on 'difference' and 'post-colonial feminism' [229, 232, 442]. However, the findings contribute to this concept by also pointing to the multiple systemic levels at which women are marginalised; women's experiences of 'multiple marginalisation' are informed both by the structures marginalising women as well as the characteristics for which they are marginalised.

Marginalisation contributed to women's exposure to stressful events, and seemed to be at the root of the processes compromising women's mental health and well-being. For example, the marginalisation women experienced because of their gender in some cases contributed to their exposure to abuse. Socio-cultural expectations regarding women's roles and social value in some cases facilitated violence against women and prevented women from accessing support resources [171, 232, 496]. This confirms findings of other researchers who have also identified this using qualitative methods [104, 246, 252, 497].

Experiences of multiple marginalisation were highlighted in the narratives of migrant women, second generation women, and other ethnic minority women because of the intersection of their ethnicity and migrant status (including the migrant status of their parents or the perception by the British majority that they weren't 'British'). Women described being marginalised or 'othered' because others thought they did not belong in the UK or weren't 'British', for example because of how they looked (their visibility as migrants or minorities), and/or because of their English proficiency or accent (or that of their parents). This included discrimination or social exclusion by others because they did not 'sound' British, as well as marginalisation due to the challenges their limited English proficiency presented for accessing information (e.g. relating to immigration procedures, application forms, or their rights), pursuing employment, or seeking services.

It was evident that the experiences of marginalisation of migrant women who were visible as 'minorities' because of how they looked and sounded differed from migrant women (or second generation women) who are perceived to be a part of the majority. As I discussed in chapter 5, section 5.3.3.8.3 (page 188), I was also aware of this in my own experience. My experience of immigrating to the UK was informed (and facilitated by) being a white English speaking migrant, and differed vastly in some ways from migrant women in the UK who have been marginalised because of their minority ethnic status and limited English proficiency.

These findings are in line with previous research which has identified that marginalisation may present barriers to accessing resources [104-109], and that associated experiences like discrimination may increase the risk of psychological symptoms [63, 89, 96-103]. There is also clear evidence from qualitative research that language barriers can limit women's ability to access care, the acceptability and effectiveness of care, and women's awareness of available services [104, 156, 321]. However, this study moved beyond previous research, which has typically looked at marginalising events (like discrimination) in isolation. The results frame these experiences as part of a process, which acknowledges the multiple and chronic marginalisation women experience over the life course (and the process of migrating).

The findings also revealed how marginalisation was cyclical and cumulative, and contributed to further marginalisation over time. Migrant women described the multiple marginalisation they experienced because of the impact their migrant status had on their socio-economic status. Women described a range of barriers to accessing employment, including language, a lack of transferability of qualifications, and their legal status. This consequently impacted on their socio-economic status, resulting in further marginalisation. Consequently, women described experiencing downward mobility, which has been shown to increase the risk of psychological symptoms [498].

The effects of this loss of socio-economic status and subsequent marginalisation on women's mental health and well-being were highlighted by women who had a high socio-economic status prior to migrating and had experienced significant downward mobility. The salience of downward mobility has also been identified in other qualitative research [156], and may provide insight into some of the findings of the quantitative study. For example, migrant women from medium IHDI level countries of origin were suggested to be at increased risk of experiencing high levels of psychological symptoms; this may be because they are more likely to experience downward mobility following migration (chapter 4, sections 4.2.4.2, page 142, and 4.2.5.1, page 148).

In addition, women without leave to remain described the downward mobility they experienced because of the restrictions on paid employment they faced, as well as their limited access to financial resources (e.g. no recourse to public funds). These factors contributed to financial instability, often including poor housing conditions and food insecurity. Furthermore, they limited women's ability to engage or integrate, to develop their skills, or to access support resources. These barriers negatively impacted on women's mental health and well-being, and contributed to their disempowerment. The marginalising effects of the restrictions on access to public funds or the ability to work in particular (including financial instability and barriers to integration) have also been highlighted by other authors [107, 127, 128], and identified as salient concerns in qualitative interviews with migrants[100].

Migrant women, particularly those without leave to remain, also highlighted how they perceived they were marginalised within the immigration system. Women spoke about

barriers to accessing services, and the complicated or confusing nature of the immigration system. Women also described being poorly treated by immigration officials, and the stressful or intimidating processes they had been required to go through. These experiences have important implications, particularly as asylum applications are contingent on the disclosure of sensitive events to immigration officials.

The length of time women described immigration processes took (e.g. decisions on their asylum applications) was also perceived to be a significant stressor, and to be marginalising because of the ongoing implications it had for women's access to resources (e.g. public funds, services), their right to work, their financial status, and their ability to settle. The stressors associated with this period have also been reported in other qualitative interviews with asylum seekers [100]. These periods of uncertainty were also associated with a feeling of powerlessness, and instability or worry about their status and the outcome of their applications. Insecure or temporary legal status has been found to be associated with higher levels of distress [96, 113, 114], and longer periods of insecure legal status have also been found to be associated with poorer quality of life [124]. This study contributes to this existing research by demonstrating the ways in which women perceive they are marginalised during this process.

The findings demonstrate that marginalisation is experienced across diverse groups of women. The findings also illustrate the salience of 'multiple marginalisation', due to the intersection of marginalised statuses and marginalisation at multiple levels. Marginalisation was found to compromise women's mental health and well-being and their access to coping resources, and to contribute to their exposure to stressful events. The results therefore confirm the need not only to recognise the relationship between marginalisation and health when addressing women's health needs, but also to develop strategies to address social inequalities or oppression at multiple levels.

7.1.2.2 "You're not as free as you want to be" - Disempowerment

Processes of disempowerment limiting women's agency, power, or control adversely impacted on their mental health and well-being, contributed to their exposure to stressful events, and limited their ability to access coping resources. Powerlessness, or a lack of control or 'agency', has been shown to increase the risk of psychological

symptoms [257], and has been identified as a salient theme perceived to negatively impact on mental health and well-being in studies using qualitative methods [220, 221, 258]. However, this study moved beyond existing literature by conceptualising the loss of power or control women experience as a process of disempowerment, through which structures at the micro, meso, and macro-level contribute to women's oppression.

This conceptualisation points to the multiple relationships in which women may be disempowered, and illustrates that disempowerment is enacted on women, rather than characterising women as powerless. 'Powerlessness' suggests an all-encompassing and static state, and problematises women rather than targeting the systemic factors contributing to their oppression. However, the concept of 'disempowerment' accommodates areas in which women may retain agency.

This conceptualisation also contributes to the literature by framing women's disempowerment in a temporal context, which shows how women's levels of control or agency change over time through their oppression. It also acknowledges that disempowerment may be chronic or cyclical, for example that disempowerment in one area can contribute to further disempowerment, or that women's disempowerment prior to, during, and following their migration was often interrelated.

In this study, both migrant women and women born in the UK described how the marginalisation they experienced because of their gender (e.g. social expectations relating to women's roles or activities) contributed to their disempowerment. Women described the lack of control they had in relation to decisions about their marriage, their ability to leave a relationship, their social interactions, or their roles. In some cases, this disempowerment also contributed to women's lack of agency in the decision to migrate.

Several of the women I spoke with had little choice surrounding the decision to migrate or the trajectory of their migration, and were forced to migrate due to the need to flee their countries of origin (e.g. due to conflict or threat of violence), or were expected or forced to migrate to the UK by others (e.g. by family or partners, or trafficking). Women perceived that their lack of agency surrounding their migration had an adverse effect on their mental health and well-being.

Migrant women also described the ways in which they were disempowered through legal structures in the UK following migration (which was in some cases related to the lack of agency they experienced prior to migration, for example as forced migrants). Women without leave to remain, for example, described how they were disempowered through restrictions on their ability to work or to access support (e.g. accommodation, financial support, or services). Women also felt powerless in relation to decisions surrounding their legal status (e.g. the length of application processes, or the outcomes of their asylum applications). Previous qualitative research has also identified these experiences of powerlessness among asylum seekers [107]. However, this study illustrates how these experiences of powerlessness are interrelated with other processes (e.g. marginalisation), as well as exposure to stressful life events.

Women's experiences of disempowerment were often interrelated with exposure to abuse. Women described both how being disempowered facilitated their abuse, and how they were disempowered through abuse, which was in some cases perpetrated in order to achieve women's subordination (e.g. the use of abuse or threats of abuse to disempower or control women). These experiences also presented barriers to seeking help or escaping abuse. The relationship between power and abuse has been discussed by other authors, including in relation to social or cultural structures [232, 233, 496, 499], and legal structures disempowering women [157, 171, 496, 500-503], which enable the perpetration of abuse or compromise women's ability to address it.

One of the experiences of disempowerment that was highlighted because of how it contributed to women's exposure to abuse related to the restrictions women faced due to their legal status. Women without leave to remain in the UK (including asylum seekers, and dependants) described experiencing powerlessness in their relationships and their ability to leave these relationships (e.g. when they were experiencing abuse) due to the limitations they faced because of their legal status (e.g. bar on paid employment, no recourse to public funds, and insecure legal status or fear of detention or deportation). In some cases, women's legal status was deliberately used by others to subordinate them and restrict their access to support resources.

Previous authors have also discussed how women's legal status can increase their vulnerability to abuse, facilitate their subordination by others, and compromise their

ability to seek support [125, 126, 496], and migration policies in the UK have been criticised for limiting women's ability to leave abusive or oppressive situations [157, 500, 504-506]. In in-depth interviews with 30 South Asian women who had experienced domestic violence, Anitha identified that a lack of access to safe accommodation and financial resources (e.g. due to restrictions on access to public funds) prevented women whose migrant status was dependant on their partners from leaving abusive relationships. Furthermore, the barriers to reporting abuse (e.g. language, lack of knowledge of systems or services in the UK), and the inconsistency and ineffectiveness of services when women were able to seek help, resulted in women's continued exposure to abuse, and inability to provide sufficient evidence of their abuse under the Domestic Violence Rule [506].

The extensive evidential requirements of the Domestic Violence Rule for dependent migrant women have been criticised as they do not take into account the challenges migrant women may face in documenting their abuse. These include women's inability to contact services whilst they are in abusive situations; inability to disclose abuse to services due to language barriers, fear of deportation or separation from their children, or fear of a lack of confidentiality; or a failure of services (e.g. particularly non-specialist services like GPs, or providers who may also treat other family members) to adequately document their exposure to abuse, resulting in a lack of records [506].

This study contributes to the discourse on the implications of legal restrictions for women's vulnerability to abuse by pointing to how women's marginalisation, disempowerment, and isolation at the micro, meso, and macro-level contribute to their exposure to abuse. This highlights the need for a systems level approach to reduce migrant women's exposure to abuse and to increase their access to support.

While efforts have consequently been made in immigration policy to accommodate migrant women experiencing domestic violence [506], the findings suggest these issues continue to affect women. Further steps could be taken to address the multiple levels in which migrant women are disempowered (including by the state and in their relationships), and their social and health needs. This includes addressing barriers to escaping abuse (e.g. isolation, financial instability exacerbated by restrictions on the right to work and no recourse to public funds, lack of safe accommodation, threat of

deportation or detention, or fear of effects for children), ensuring accessible information about women's rights and resources is disseminated to them, and improving the availability and accessibility of services (ensuring they are prepared to address women's needs, e.g. through adequate training).

This study confirmed previous research showing that there are adverse health implications of experiencing disempowerment for both migrant women and women born in the UK. Marginalisation and isolation contributed to women's disempowerment, suggesting policy and services should aim to address processes contributing to women's disempowerment through a systems-level approach when addressing their social and health needs.

7.1.2.3 "You feel alone in the battle" - Isolation

Isolation, including the loneliness associated with it, and the barriers it presented to accessing support resources, was perceived to have a negative impact on women's mental health and well-being. Previous studies have identified that isolation is a key theme compromising mental health and well-being, and access to support resources [106, 220, 221, 507, 508]. Furthermore, research has identified that social support and social capital are inversely associated with psychological symptoms [374, 509]. However, research often only examines isolation as a static factor.

This study shows how isolation changes over time, how processes like marginalisation and disempowerment contribute to women's isolation, and how women's isolation contributes to their exposure to stressors and presents barriers to accessing support resources. This reflects what Northcote refers to as a 'cycle' of social isolation, which focuses on multiple factors contributing to and perpetuating women's isolation, rather than conceiving of such factors as independent [510]. This cycle is particularly visible in the process of isolation experienced by migrants in the periods leading up to and following migration, which I was able to examine due to the life-course approach in the interviews.

Prior to migrating some migrant women described the loss of loved ones due to the conditions in their countries of origin (e.g. through separation due to flight, or death). This also occurred during migration (e.g. when women were initially separated from

their communities upon migration, and in some cases due to their separation from or loss of loved ones whilst in transit). For many women, this separation from their loved ones was long lasting because of the circumstances of their migration (e.g. forced migration), or an inability to return to their countries of origin or for their loved ones to come to the UK (e.g. due to conflict, or legal or financial reasons).

Women also described the increasing isolation they experienced in the UK following migration, for example due to language barriers and the feeling that they could not engage or connect with people. Language barriers resulted in women's isolation from support resources, for example health services. Language also presented barriers to work or education, as did women's legal status or a lack of transferability of qualifications, which also limited women's social engagement and integration. Furthermore, this contributed to women's financial instability, which resulted in further isolation from their communities and presented additional barriers to social engagement or accessing support resources. For example, migrant women spoke about being unable to afford transportation, phone cards, or to participate in clubs or activities, as well as being unable to visit their countries of origin because of their limited financial resources. Previous authors have discussed the isolating effects of migration policies like restrictions on asylum seekers' ability to work, because of the barriers to integration that the financial instability and social exclusion they experience presents [511-513]. Furthermore, qualitative research has found that women's ability to engage in work greatly facilitates their engagement and integration [514]. This study contributed to the literature, however, by showing the multiple factors throughout migration that contributed to the process of isolation for migrant women.

Women also described how the marginalisation they experienced in the UK due to their ethnic status or migrant background (e.g. social exclusion or discrimination) contributed to their isolation and limited their ability to integrate or develop their social networks. This is reflected in other studies using qualitative methods [104, 106, 507]. For example, in Casimiro et al's semi-structured interviews with 80 Muslim women, they similarly identified that the negative attitudes women experienced from those in the host country due to their ethnic background contributed to their feelings of isolation[507].

Women's anticipation of marginalisation (e.g. discrimination or racism) because of these statuses also resulted in some women's self-isolation (e.g. avoiding engaging with individuals or integrating in the community). Similar findings have been reported in a qualitative study of Ethiopian refugees in the UK where participants described a fear of being misunderstood, and their self-isolation as a result of this anticipated marginalisation [100]. Women also described fears relating to confrontation with officials or deportation, which also resulted in their self-isolation and impeded women's integration and help-seeking. Self-isolation may also prevent these women from being represented in research (see section 7.2.2, page 269), and efforts need to made in future research to address these barriers.

In the narratives, women described how in some cases these fears and their self-isolation stemmed from a lack of knowledge about their rights in the UK. Women described that when they were able to obtain documents to prove their status and rights, they felt more confident and less afraid. Ensuring migrant women are provided sufficient and accessible information about their entitlements in the UK may help to reduce these fears and facilitate women's engagement and integration in their communities. Women also spoke about the salience of being able to connect with people with similar experiences or from similar backgrounds, because this helped them to develop their social networks in the UK and facilitated their integration into their communities. Further research is needed to provide more insight into what characteristics or experiences may contribute to (or prevent) women's self-isolation, and additionally, what services or resources may reduce women's isolation.

A salient finding in the qualitative study related to the interrelationship between isolation, disempowerment, and abuse. Women's isolation facilitated their subordination because of their lack of support resources. In some cases, isolation had been used as a tool to subordinate them, including confining them to where they were living, restrictions on who they could interact with or their activities (e.g. employment), or requiring them to be accompanied (for example in social situations or when seeking services). Some women also described that abuse or the threat of abuse was used in order to enforce their isolation.

Enforced isolation was both disempowering and abusive, and resulted in limitations on women's ability to access resources like social support or health services. Other authors have also framed enforced isolation as a form of abuse, and discussed the barriers to accessing support that women may consequently experience [496, 515, 516], though studies often overlook other factors that compound women's isolation (e.g. legal or language barriers). While women's legal status in some cases facilitated their enforced isolation, it is important to recognise that this type of abuse is experienced by both migrant and non-migrant women.

7.1.2.4 "This gave me strength" - Coping

In the narratives, I identified coping processes which women perceived enabled them to address stressors and manage changes in their mental health and well-being. The coping resources (e.g. individual characteristics, coping strategies, and support resource) and empowerment strategies women identified reflect previous conceptualisations of coping resources and proactive coping strategies [517, 518]. However, the findings contribute to the literature, which discusses these coping strategies in isolation, by framing coping as a process, integrating women's coping resources and active strategies, and examining the salience of these mechanisms across the life course (e.g. prior to/in anticipation of stressors, whilst stressors are being experienced, and following stressors or in relation to changes in their mental health and well-being).

The findings also highlight women's *active* position in relation to these coping processes and their mental health and well-being. Rather than representing themselves as helpless, passive, or incapable, women instead emphasised their own strength and agency. This is in contrast to literature that focuses on the vulnerability or powerlessness of women confronted with stressors or poor mental health, and their corresponding low self-esteem or hopelessness [519-524]. While research with diverse communities of women haven't typically depicted proactive, self-effective self-images, in in-depth interview with 12 Black Caribbean women in Manchester (UK), Edge and Rogers highlighted women's perceptions of their strength, and sense of mastery or agency in the coping process [525]. While it is important to recognise the effects that experiences like abuse or marginalisation can have on self-esteem or beliefs in self-efficacy, recognising the coping resources women utilise or have access to can inform

the development of strategies to help them address stressors or manage changes in their mental health and well-being.

Support resources were identified to be particularly salient coping resources, and the women I spoke with highlighted the importance of both emotional support (which made women feel loved or cared for, or gave them someone to talk with about their experiences) and instrumental support (which included financial support, accommodation, childcare, or help in an emergency). Such support helped women to access coping resources (including social, legal, or health services), or to escape stressors (like abuse, particularly if they were dependent on the perpetrators of abuse). The salience of these forms of support was contributed to by the intersecting marginalisation, disempowerment, isolation, and barriers to accessing support women experienced. These results reflect the findings in the cross-sectional study that women with high levels of social support (including emotional or instrumental support) or larger social networks were at decreased risk of experiencing high levels of psychological symptoms.

Migrant women in particular experienced a loss of social networks, difficulties in being able to 'connect with loved ones' (e.g. in their countries of origin), a lack of new networks in the UK, barriers to integration, and financial instability, which resulted in their need for both emotional and instrumental support. The loss of support resources and socio-economic status migrant women experienced, and restrictions on their access to financial resources like public funds, may also help to explain the finding in chapter 3 that migrant women reported having significantly less instrumental support than women born in the UK (see section 3.4.4.1, page 106).

The salience of processes of isolation and the importance of emotional and instrumental support as coping resources was a key juxtaposition in the findings. In some cases, the isolation women experienced (or their lack of social support) was linked to experiences of loss and separation (e.g. due to migration, or the death of a loved one). In some cases, these experiences of separation and loss were stressful events because of the circumstances of the separation, the inability to reconnect or chronic separation (e.g. due to migrant status, conditions in one's country of origin, financial barriers, or the death of a loved one), and the implications of separation and loss for one's isolation.

While stressful life events and isolation/level of social support were examined separately in the cross-sectional survey and in the findings of the thematic analysis, it is important to recognise that loss or separation may increase the risk of psychological symptoms due to the stress or trauma associated with these experiences, the duration of separation and loss, and the loss of support resources. The association of separation and loss with psychological symptoms has been documented in previous research, particularly for migrant populations[19, 62, 75, 526].

While the protective effects of emotional and instrumental support has been recognised in the literature [344, 374, 526, 527], it should not be assumed that having social networks implies the availability of social support or an absence of isolation (for migrant or non-migrant women). For example, even when surrounded by family (e.g. living with parents, partners, in-laws) or other members of their community, women were in some cases unable to access the support or quality of social relationships they desired [471].

Women described the salience of not having anyone to talk to, to provide companionship, or to make them feel loved or cared for (even when they had family members or acquaintances in the UK). In some cases women also felt unable to discuss their health needs or disclose abuse because of fear of stigma or further violence, because it was too difficult, or because confidentiality was compromised (e.g. when they were escorted when accessing services or if service providers also had relationships with partners or family members). There were also instances where women's families or community members were condoning or perpetrating the abuse they were experiencing [528], or enforced their isolation in other respects (e.g. restrictions on their social interactions, activities, or access to services) [496, 515, 516]. In qualitative interviews with 23 South Asian women who had experienced intimate partner violence, Raj et al identified that in-laws were often aware of or even supported the perpetration of intimate partner violence against the women, and that women also experienced physical abuse and emotional abuse (including isolation and domestic servitude) from in-laws [528].

Empowerment

In the narratives women described strategies including 'action', 'resistance', and 'independence' that were associated with their strength and agency, and helped them to

cope. Women utilised these empowerment strategies to confront situations in which they were marginalised, disempowered, or isolated. These findings support previous research which suggests that empowerment strategies may be associated with improved mental health and can contribute to women's ability to address stressors [529, 530]. For example, in a randomised control trial with 110 pregnant women with a history of abuse recruited from an antenatal clinic, Tiwari et al identified that women who received empowerment training had significantly higher physical functioning, improved role limitation scores, lower postnatal depression scores, and reported less psychological abuse and minor physical violence compared to women in the control group who received standard care [529].

The salience of women's empowerment strategies in their narratives reinforced the value of conceptualising women's experiences of oppression as part of a process of disempowerment. This provided space for women to have agency or to utilise empowerment strategies (rather than conceiving of them as powerless, which implies a permanent condition within which women have no agency or power). Furthermore, the empowerment strategies women described situate the woman as agent, and highlight that they are acting or resisting against or gaining independence from an external force. This reinforces that women are disempowered by systemic factors, rather than being powerless objects.

In research and public discourse, strategies that enable women's empowerment are often overlooked, as is women's resilience. Women have sometimes been constructed as 'powerless', 'helpless', or passive, and their 'vulnerability' to stressors or poor mental health outcomes emphasised, without recognising areas in which they have agency, power, or control [159, 261, 531-533]. Such images can perpetuate negative stereotypes or perceptions of these communities as a burden or problem, and further contribute to women's marginalisation or disempowerment, particularly if such assumptions are perpetuated in policy or services [531-533]. Thus, services should aim to identify and evaluate ways of aiding women's empowerment in efforts to address their health and social needs.

7.1.3 Conceptualisations of mental health and well-being

Women described changes in their 'emotional health' and their 'whole body' over their life course, which they attributed to the stressful life events and processes identified in this study. How women spoke about these conceptualisations was informed by their experiences, as well as their current circumstances.

7.1.3.1 Emotional health

Both migrant women and women born in the UK described feelings of anxiety, feeling sad or down, and cognitive disruption. There were some conceptualisations of emotional health that were specific to migrant women, however.

In the narratives, migrant women often did not use psychiatric terms to describe their emotional health, particularly when they were not from 'Westernised' countries or had not been in the UK for long. The use of emic illness models or non-Western conceptualisations of illness has the potential to present barriers for women when help-seeking, for example the accessibility of biomedical services, the recognition by service providers of women's needs, women's understanding of the diagnosis or treatment they receive, and its acceptability (e.g. in relation to their own illness models or beliefs) [109, 265, 266, 431, 534-537].

In some cases, the onus is placed on migrants to improve their 'health literacy' (valuing knowledge of Western or biomedical illness models over knowledge of emic models). This can disadvantage migrant populations, both by placing the burden of improving access to care on the migrant, as well as removing the burden from research, policy, and services to identify strategies to address these communities' needs. Services must be able to accommodate individuals with limited English proficiency, limited biomedical health knowledge, or differing illness models.

When describing feelings of anxiety, migrant women often emphasised the accumulation of stress they experienced, or the feeling that no part of their life was free from stress. The life-course approach of the qualitative study enabled me to identify the accumulation of stressors women experienced over time, as well as their experience of multiple stressors simultaneously. This made the relationship between the accumulation of stressors and when women perceived they experienced changes in their mental health and well-being visible.

Anxiety and other symptoms associated with the accumulation of stressors are experienced across communities. However, migrants' exposure to multiple or cumulative stressors, and its effect on their mental health has been acknowledged specifically in the literature. The symptoms resulting from exposure to chronic and multiple stressors by migrant communities have been referred to as the Chronic and Multiple Stress Syndrome or 'Ulysses Syndrome' [371, 538-540]. This concept describes the systemic exposure to stress migrants experience at the individual as well as the community or structural level throughout migration (prior to, during, and following migration). It recognises symptoms relating to depression, anxiety, somatisation, and dissociation, as well as acknowledging experiences of distress that may be framed within other culturally specific illness models, and the validity of these experiences though their symptoms may not fit within a specific diagnosis. This conceptualisation has been promoted as a more comprehensive approach to understanding migrants' mental health and well-being than biomedical approaches, which have been criticised for being unable to accommodate experiences of distress that do not fit into isolated psychiatric diagnostic categories (and consequently under diagnosing, misdiagnosing, or medicalising migrants), or for overlooking the intersecting factors that inform migrants' health needs [371, 538].

When speaking about 'feeling sad or down', several migrant women described 'thinking too much'. This concept has also been identified in other qualitative studies with migrant populations or communities in other 'non-Western' countries [541-546], and it has predominantly been discussed in relation to depression. In some of the narratives, it seemed that women's experiences of 'thinking too much' were related to 'feelings of anxiety' or physical or embodied experiences of distress. This is reflected in other research, for example in Krause's ethnographic research with Punjabis in the UK, in which thinking too much was discussed in relation to heart distress ('sinking heart'), as well as worry, anxiety, and unhappiness [545], or Abas et al's semi-structured interviews with 172 women in Zimbabwe, in which women used the concept of 'thinking too much' to describe their experiences of distress [546]. While previous studies have also identified the experience of 'thinking too much', this study provides additional insight into factors that may contribute to or exacerbate this experience of distress. For example, women described how always being home, having no one to talk to, or being

bored lead to them 'thinking too much'. This reflects how the experiences of isolation and disempowerment some women experienced impacted on their mental health and well-being.

Both migrant women and women born in the UK spoke about cognitive disruption. Both groups of women described experiencing memory loss, which in some cases was perceived to be related to a stressful or traumatic experience. However, migrant women also spoke about changes in their cognitive functioning (e.g. confusion) and the limitations it had for their daily lives. These experiences of cognitive disruption or inconsistencies in memory have been identified in other research with migrants, frequently in the context of exposure to trauma [547, 548].

Often cognitive impairment in traumatised populations is described in the context of PTSD [182, 549, 550]. The universality of PTSD has been questioned, however, for example because it may not be valid or appropriate cross-culturally or for individuals with repeated or chronic exposure to trauma (e.g. refugee or asylum seeking populations) [273, 551]. Furthermore, its use in migrant populations exposed to trauma has also been criticised for potentially medicalising normative experiences of distress or reactions to trauma and loss; for labelling these populations as 'high risk', 'diseased', or a 'burden'; for focusing on previous exposure to trauma and rather than current stressors contributing to their health needs (e.g. in the host country); and for overlooking instances of recovery or resilience [272, 551-553]. Furthermore, there is no consensus regarding the efficacy of or best treatment for PTSD in these populations [554].

However, the utility of this diagnosis has also been asserted, and these criticisms acknowledged as an indication of the need to refine the diagnosis in these populations, rather than reject it [464]. Though there may be limitations to the diagnosis of PTSD, it is argued that this does not negate the validity of this diagnosis, as there is evidence of the biochemical or anatomical changes that accompany it, and of the clinically significant levels of distress and impairment some individuals experience following exposure to trauma [464]. Furthermore, the diagnosis may be useful in validating the symptoms experienced by individuals following trauma, which may be particularly important, for example, in relation to asylum claims. However, in general the women themselves did not refer to PTSD while depression was a term they used; this has implications for

health professionals who may focus on the depression without considering that post-traumatic symptoms may also be present and impacting on functioning. Similarly a lack of focus on PTSD may be unhelpful in asylum claims.

A lack of understanding of the impact of trauma on cognitive processes (e.g. among immigration officials) may be particularly salient for asylum seekers because of the challenges presented by confusion, memory loss, or forgetfulness when applying for asylum. For example, women described becoming confused or not being able to remember certain details in court proceedings or asylum interviews. These effects had the potential to present barriers to providing the information needed to justify their applications for asylum, or to compromise the perceived validity of their claims (e.g. if they were perceived to be inconsistent or incoherent) [547, 548, 555-557].

In addition, the asylum system may exacerbate the psychological symptoms experienced by asylum seekers (and also further compromise their ability to provide the coherent evidence needed when applying for asylum), due to the stresses of applying for asylum and waiting for a decision, as well as the re-traumatisation of these individuals that may occur by requiring them to revisit their experiences through (multiple) interviews [558, 559]. In the narratives, women who had sought asylum highlighted the stresses associated with the asylum process, and the impact they perceived it had on their mental health and well-being including both their feelings of anxiety, and cognitive disruption.

7.1.3.2 Whole body

In addition to the changes women described in their emotional health, women also talked about how they conceptualised the relationship between their emotional health and their bodies, which is described by the theme 'my whole body'. This theme includes women's descriptions of changes in their body or functioning (physical changes they perceived to be related to their emotional health), and their embodied experiences of changes in their mental health and well-being. The migrant women I spoke with often used metaphors to describe these embodied experiences, in some cases not distinguishing between 'mental' and 'physical' symptoms. There is a substantial body of literature documenting the use of 'embodied metaphors' or 'idioms of distress' in non-Western or non-English speaking populations [535, 543, 545, 560-567].

Within a biomedical framework, this is often conceptualised as 'somatisation' (expressions of physical symptoms that may be associated with mental illness or distress rather than a physical cause), which has been suggested to be universal, and highly prevalent [460, 567-571]. 'Cultural somatisation', specifically, refers to the presentation of somatic symptoms because of language barriers, discrepancies in illness concepts, or stigma or other social barriers that prevent the expression of the 'true' illness experience or symptoms [567]. However, the concept of somatisation and its use in psychiatry has been criticised for being a 'black box' or 'catch all' label, neglecting diverse conceptualisations of illness or the use of metaphors (to describe distress or grief, or patients' mental, physical, or social needs), and for potentially medicalising normative experiences (for example of grief or distress) [269, 546, 564, 572-575]. Furthermore, the dichotomisation of 'Western' and 'non-Western' understandings of illness, and the privileging of biomedical models can result in the othering or disvaluing of the illness experience or knowledge of populations with diverse illness models; this assertion of the biomedical health model as the dominant and 'valid' system has been referred to as 'medical imperialism' [576].

The embodied metaphors and conceptualisations of health described by some of the migrant women I spoke with in relation to their 'whole body' may also conflict with the dichotomisation of 'body' and 'mind' within the Western biomedical framework. The presentation of physical symptoms or the use of embodied metaphors to describe psychological or social distress in a biomedical setting may present barriers to the diagnosis or treatment of migrant women (e.g. resulting in misdiagnosis or a failure to diagnose women based on discrepancies between women's own conceptualisations of illness and Western diagnostic categories) [568, 577, 578].

This study described how women conceptualised and experienced these changes in their mental health and well-being, rather than seeking to explain the pathology of symptoms or frame their meaning within a biomedical framework. The results show differences (e.g. embodied metaphors or confusion) and similarities (e.g. anxiety or feeling sad or down) across populations of women in the experience and conceptualisation of mental health and well-being.

The findings also complemented the cross-sectional study. Some of the changes women identified in their mental health and well-being reflected the psychological symptoms measured by the CIS-R and PTSD screen. However, other conceptualisations may not have been captured by these instruments, and the use of in-depth interviews enabled diverse experiences of illness to be represented. Though these measures have been validated in diverse populations, the use of such measures in migrant populations has been questioned. Psychiatric diagnostic categories may not be able to accommodate non-Western conceptualisations of illness [269-274], accurately distinguish between disorder and normative distress or bereavement [64, 269, 271, 273, 382], or contextualise diagnoses in relation to other concerns that may be contributing to presented symptoms (e.g. social or economic needs) [272].

The findings illustrated that women's illness experiences and health needs may not always be presented within or directly translatable to a psychiatric framework (e.g. women may not use psychiatric terminology, may not conceptualise their illness experience within a biomedical illness model, may present physical symptoms, or may not conceptualise their symptoms as 'disorder'). This is significant because of the potential barriers this may present to help-seeking for women from diverse backgrounds, or to the assessment and treatment of these women [109, 265, 266, 431, 534-537].

The findings suggest that migrant women in London may have significant mental health needs, but that in order to accommodate these needs, services need to be aware of diverse experiences of illness and identify the range of factors contributing to changes in mental health (e.g. exposure to stressful events, marginalisation, disempowerment, or isolation). Furthermore, services must be able to accommodate individuals with limited English proficiency, unfamiliarity with biomedical health terminology, or differing illness models. Ultimately, services should aim to provide treatments that will be acceptable and effective for women given these factors, and to incorporate women's coping strategies into their care in order to empower them and facilitate their recovery in the treatment process.

7.2 Strengths and limitations

7.2.1 Strengths

This study used purposive sampling to attempt to obtain a sample of women representing a range of ethnic backgrounds, ages, regions of origin, and experiences of migration. I also included women who did not speak English or who had limited English proficiency, and used rigorous cross-language qualitative research methods guided by the review presented in chapter 2 (page 50). This allowed women from a range of backgrounds to be represented. I was also able to include women who were not represented in the quantitative study as they did not live in private residences, for example women living in shelters or supported accommodation, as well as homeless women.

The topic guide used a narrative approach to enable women to identify significant experiences across their life course (including prior to, during, and following migration), and to describe their experiences in the temporal context within which they were experienced. This not only provides necessary context, but also allows the participant to construct narratives in the order in which she experienced them, which contributes to the spatial and temporal contiguity of the narrative from the focal point of the participant [478].

The semi-structured in-depth interviews enabled women to define what was meaningful in the research, allowing them to identify what experiences they perceived to be significant, and how a range of experiences over the life course affected them. The topic guide also enabled women to engage in the research in their own terms (e.g. language or idioms). This enabled the research to overcome some of the limitations of what has been termed 'black box research' by accommodating diverse conceptualisations of health and illness. This was also achieved through the inclusion of a question at the end of the interview that asked participants if there were other topics they would like to discuss or perceived to be significant that were not included, which further enabled women to direct what was examined in the research. An additional strength of the topic guide is that it was developed in consultation with experts in the field and migrant women, and was piloted with researchers, migrant women, and individuals who were not native English speakers. This benefit the research by providing insight into salient topics, and improving the acceptability and comprehensibility of the interview guide.

In this study I did not seek to identify differences between groups of women based on their cultural or ethnic background. Instead, I focused on exploring how underlying factors like the intersection of multiple statuses, and processes of marginalisation, disempowerment, isolation, and coping contributed to women's lived experience and changes in their mental health and well-being. These factors may inform patterns identified in previous research that have been attributed to ethnic or cultural factors [229, 442, 579-581].

For example, rather than seeking to isolate differences in women's exposure to abuse based on their ethnic or cultural background in the analysis, I aimed to identify processes that resulted in, facilitated, or perpetuated women's exposure to abuse. While some socio-cultural factors may contribute to abuse, women's exposure to abuse is not necessarily caused by these factors. 'Culture' is not an isolated or static entity, and is informed by social processes; attributing women's exposure to abuse to cultural factors has the potential to simplify or misrepresent their experiences, as well as to stigmatise their communities [229, 442, 579-581].

In some research such underlying processes have not been acknowledged [229, 442]; specific cultural or ethnic groups have been singled out or stereotyped for having high rates of, or an 'acceptance' of abuse. Research which points to the 'differences' between these communities and other populations, or attributes abuse to 'cultural factors', has the potential to 'other' these communities, and overlook the abuse taking place in other (e.g. majority) communities or the structures contributing to it [442]. Conversely, some research neglects differences in experience across diverse groups of women, or how the intersection of the statuses women identify with (e.g. migrant status, ethnicity, or class) may contribute to their exposure to abuse. Such research risks simplifying or misrepresenting women's experiences because it lacks engagement with the multiple marginalisation or oppression women may face, and how it contributes to abuse and impacts on their mental health or well-being [167, 228, 229, 532, 582].

Categorisations relating to women's cultural or ethnic backgrounds are often used uncritically in research based on the assumption that they denote isolatable or uniform groups [583, 584], which overlooks the heterogeneity within groups or commonalities across groups [583-585]. Such 'black box' research [583] ultimately decontextualises these statuses

and overlooks other significant factors (e.g. intersecting statuses or underlying processes) that contribute to associations identified in research between culture or ethnicity and social or health needs. The uncritical use of these categories based on assumptions about the characteristics of certain groups can result in their essentialisation or stereotyping, and their further marginalisation or stigmatisation [110, 329, 442, 583, 586]. Furthermore, it can lead to the misinterpretation of research findings and a failure to identify important risk factors that may require attention, which may consequently misinform policy or services, resulting in inadequate care [583, 585].

7.2.2 Limitations

The sample of women I recruited from the SELCoH Study and community organisations may not be representative of the larger population of women living in London; the participants may have experienced fewer language barriers, been more integrated or more acquainted with services in the UK, had better access to support resources, or been more willing to participate in research or disclose their experiences than some groups of women. Women experiencing greater barriers to integrating or seeking support resources may be less likely to be engaged in community organisations, for example, and thus may not have been represented. It is also important to point out that the population of migrant women living in London may not be representative of migrant populations in other parts of the UK or other countries, and thus the results may not be generalisable to other settings.

I also found that some groups of migrant women were particularly difficult to recruit, including women who had been trafficked or who had been in the UK a shorter period of time. I recruited one woman who had been trafficked to the UK, and as described in section 6.2.2.2 (page 194), the mean length of time migrant women in the sample had been in the UK was 16.21 years [s.d. 10.3, range 7-49]. The difficulties I experienced in recruiting these groups may have been due to several factors, including small numbers of women in these groups in London, low numbers of these women in contact with community organisations or living in private residences, or the hesitance of organisations working with these groups of women to allow me to invite these women to participate, as their needs may have been more extensive. Furthermore, the barriers identified in this study that women experienced in other areas (e.g. to accessing

services), including language, isolation, or a fear of discrimination or deportation, may also have impacted on recruitment in this study.

In the interview I conducted in Spanish I recognise that not being a professional credentialed interpreter may have presented limitations. Though I feel confident in my Spanish language abilities, I am aware that I am not a native speaker, do not have socio-cultural or linguistic knowledge specific to the region of origin of the woman I interviewed, and do not have experience in interpreting. Thus, the interview and my translation of the interview in the transcription were necessarily limited by these factors. Similar limitations exist in relation to the interviews with women who did not speak English as a first language who elected to be interviewed in English, as this may have impacted on what they spoke about in their narratives. However, such methodological limitations exist in any qualitative interviews where the participants and interviewer have different linguistic or cultural backgrounds [295]. There are methodological challenges in both the use of translation or conducting research in a non-native language of participants. Consequently, I chose to enable women to conduct the interviews in the language of their preference (including English), which is in line with the methodological guidelines identified in chapter 2 (see section 2.4.1, page 81). It is important to note, however that in some cases there are benefits to having interviewers/interpreters who are not from the same background as the participant (see chapter 2, section 2.4.1.1, page 84); it may have been an advantage that I was not from the same community as the woman I interviewed in Spanish, as this may have reduced barriers (e.g. fear of being judged) that would have limited what she shared in her narrative.

As discussed above, I did not explore trends for specific cultural or ethnic groups, or differences between such groups in the analysis. In addition to the theoretical reasons for this, this was also guided by only having small numbers of women from each ethnic group. Some qualitative research has provided valuable insight into specific communities' experiences or health needs through interviews with individuals from particular migrant groups [156, 246, 515, 587]. However, in order to examine commonalities and differences in experience within and across a range of ethnic and cultural groups, research with larger sample sizes of women is needed, which is typically not feasible in qualitative research.

7.3 Conclusions

This study identified a range of stressful life events women perceived contributed to changes in their mental health and well-being, including their 'emotional health' and their 'whole body'. In particular, exposure to abuse was perceived to be particularly detrimental and was endemic across communities of both migrant women and women born in the UK. These findings reflect the high rates of exposure to stressful life events identified in chapter 3, which were found to increase the risk of experiencing high levels of psychological symptoms. This demonstrates the need for policy and services to recognise the high rates of exposure to stressful life events, including abuse, among diverse communities of women living in London, the impact it may have on their mental health and well-being, and consequently their health and social needs.

Four processes were found to contribute to changes in women's mental health and well-being, as well as their exposure to stressors. Women's experiences of marginalisation, disempowerment, and isolation were interrelated. These processes were experienced at the micro, meso, and macro-level, and were informed by women's gender, socio-economic status, ethnicity, and migrant background. The findings also highlight the coping processes that enable women to address stressors, and the salience of factors like social support and empowerment.

Further research is needed to provide insight into the processes contributing to women's exposure to stressors and changes in their mental health and well-being. Studies that isolate factors like socio-economic status or ethnicity without acknowledging the intersection of multiple statuses, or the marginalisation, disempowerment, or isolation that these statuses may contribute to, may perpetuate the social inequalities associated with these factors, and inform the development of inadequate policy or services. This study shows that women's health needs should be contextualised in relation to exposure to stressful events, women's statuses, processes of marginalisation, disempowerment, and isolation, and the coping resources available to women.

Services must aim to provide support relevant to women's mental health needs as well as their social needs, to be accessible (e.g. in relation to barriers presented by abuse, limited English proficiency, legal status, or a lack of financial resources), and to be acceptable and appropriate (e.g. in relation to socio-cultural factors). Services should

also aim to ensure providers are aware of diverse illness models, and that conceptualisations of health that may not be framed within a biomedical or psychiatric framework are accommodated; a failure to adequately respond to the health needs women present can result in the misdiagnosis or neglect of women's needs.

Services should also provide support to facilitate women's access to coping resources and to enable their empowerment. Coping processes should not be overlooked in efforts address women's social and health needs, but rather they should be integrated into such strategies. Further qualitative research as well as the involvement of diverse communities of women in the development of services or other programmes may facilitate the achievement of these aims.

The findings in this study demonstrate that stressful life events and underlying processes like marginalisation contribute to changes in the mental health and well-being of women across populations. However, it is important not to assume communities of women (e.g. migrants) are homogenous (in relation to experiences or needs), or to perpetuate assumptions relating to the risks or needs of certain populations of women (e.g. asylum seekers or minority ethnic groups), which may further marginalise these communities. Difference needs to be acknowledged between groups as well as within groups of women. Equally, commonalities across populations of women should be recognised, for example that abuse, marginalisation, disempowerment, and isolation are experienced by both migrant women and women born in the UK, and may ultimately impact on their mental health and well-being, and access to resources.

Chapter 8: The impact of migration and stressful life events on women's mental health and well-being: Discussion

8.1 Main findings

The review of international and UK-specific research found inconsistent reports regarding whether migrant women are at increased risk of psychological symptoms compared to native populations (see chapter 1, page 11).

Findings from the cross-sectional survey of women living in South East London (the SELCoH study, chapters 3 and 4) showed no significant difference in the risk of experiencing high levels of psychological symptoms in migrant women and women born in the UK; both migrant women and women born in the UK were found to experience high levels of psychological symptoms (29.5% [95% CI: 24.8 – 34.6] and 28.6% [95% CI: 24.9 – 32.6] respectively).

This study also found high rates of exposure to lifetime potentially traumatic events in both women born in the UK (71.4% [95% CI: 67.2 – 75.2]) and migrant women (66.5% [95% CI: 61.4 – 71.3]), which were associated with an increase in the risk of experiencing high levels of psychological symptoms (AOR: 2.0 [95% CI: 1.3 – 3.1]). In addition, both groups were found to experience high rates of long standing physical conditions (54% [95% CI: 50.0 – 58.6] and 57.7% [95% CI: 52.3 – 62.8] respectively), which were found to be associated with psychological symptoms (AOR: 1.8 [95% CI: 1.2 – 2.7]). Thus, the similarity in (high) levels of psychological morbidity in both migrant women and women born in the UK living in South East London may be partly due to the high rates of exposure to stressful life events and high rates of long standing physical conditions experienced in this part of the UK.

Local or community level factors in the area in which the study was conducted, may also have contributed to the high levels of psychological symptoms among women living in South East London [372]. For example, the high levels of deprivation (in relation to income, education, employment, health deprivation and disability, and barriers to housing and

services), ethnic density, and crime in South East London, may result in the social exclusion of women living in this community (socially, politically, economically, etc.)[372, 495, 588]. Such social exclusion or disadvantage has been shown to be associated with psychological symptoms[588]. In the English Indices of Deprivation 2010 report, for example, Southwark was ranked 25th, and Lambeth was ranked 14th out of the 326 Local Authorities in England, with lower rankings indicating higher concentrations of deprivation, proportions of the population living in the most deprived areas, and rates of income or employment deprivation[589].

The qualitative study, described in chapters 5-7, explored the relationship between stressful life events and mental health in migrant women and women born in the UK further, and also pointed to the similarities and shared experiences (as well as differences) between migrant women and women born in the UK. Women reported a range of stressful events they perceived contributed to changes in their mental health and well-being, including abuse, witnessing violence, stressful events relating to close relationships, and physical health events. In the narratives, abuse was perceived to be particularly detrimental, and was endemic among both migrant women and women born in the UK. Indeed, in the cross-sectional survey, 29.3% [95% CI: 25.5 – 33.4] of women born in the UK and 22.9% [95% CI: 18.8 – 27.4] of migrant women reported experiencing physical or sexual abuse; women who experienced physical or sexual abuse were at significantly increased risk of experiencing high levels of psychological symptoms (OR: 4.2 [95% CI: 3.1 – 5.8]).

The qualitative study examined the mechanisms for some of these associations and identified that processes of marginalisation, disempowerment, and isolation contributed to women's exposure to stressful events and to adverse changes in their mental health and well-being, and presented barriers to accessing support resources. Women were exposed to these processes across the life course at the macro, meso, and micro-level because of their gender, socio-economic status, ethnicity, and migrant status. The use of a narrative approach and an ecosystemic framework to structure how the findings of the thematic analysis were presented both enabled the multiple marginalisation women experienced across the life course at the micro, meso, and macro-levels to be highlighted, and for the

salience of this ecological model and the events women experienced across the life course (e.g. prior, during, or after migration, or stressful life events experienced in childhood or adulthood) in both the qualitative and quantitative findings to be visible. The findings suggest that the changes associated with these processes do not represent permanent conditions or characteristics of the women who experience them (e.g. powerlessness or vulnerability), which makes room for women's agency, coping strategies, and resilience.

Marginalisation was found to contribute to processes of disempowerment and isolation. Furthermore, women described experiencing 'multiple marginalisation' because of the intersecting marginalised statuses they identified with. This reflects the concept of 'intersectionality', which recognises how women's social location is defined by the intersection of multiple identities, and the social exclusion they may consequently experience socially, economically, or politically[495].

The process of marginalisation, and the intersecting statuses and multiple marginalisation women were found to experience, requires the dichotomy made in this research between individuals who immigrated to the UK and women who were born in the UK to be explored further. It was evident, for example, that minority women born in the UK still experienced multiple marginalisation due to the perception by those in their communities that they weren't British. This perception was grounded in their cultural or religious practices, the migrant status of their parents, and women's external appearance. Consequently, the experience of being perceived as a migrant was not exclusive to women who were born outside the UK; the social exclusion associated with this was also described by women who considered themselves to be British.

Given that one's actual or perceived 'migrant status' is not necessarily determined by whether they were born in the UK or born outside the UK, it is necessary to question the validity of the simplistic dichotomy between migrant and 'non-migrant' based on country of birth. Furthermore, previous research has shown that there may be a relationship between migration and health for subsequent generations, not only individuals who immigrated themselves. For example, mental and physical morbidity in first generation and second generation migrants (those whose parents immigrated), or even subsequent

generations, has been shown to differ, in most cases with subsequent generations being at increased risk of poor mental and physical health outcomes compared with first generation migrants. This has been attributed to acculturation stressors, socio-economic stressors, and the multiple marginalisation these individuals experience from both their parents' communities and the 'native' communities in their country of residence[181, 590-594].

These processes (my interpretative themes) may provide insight into the results of the cross-sectional survey. For example, marginalisation (e.g. linked to downward mobility following migration) may explain the finding that women from medium IHDI level countries of origin may be at increased risk of experiencing high levels of psychological symptoms. Disempowerment may explain the finding that migrants who were forced to migrate were at high risk of psychological symptoms.

In both studies, social support was identified to contribute to women's resilience. In the qualitative interviews, social support was described as an important coping resource, and in the cross-sectional survey, women with high levels of social support (including emotional or instrumental support), or larger social networks, were found to have a decreased risk of experiencing high levels of psychological symptoms (see chapter 3 Table 13, page 126). In addition to social resources, I identified a range of other salient coping resources women could draw upon, including women's individual characteristics (e.g. strength), active coping strategies (e.g. keeping busy or getting out), and empowerment strategies (action, resistance, or independence). In the narratives women described how they actively engaged in these coping processes across the life course (e.g. prior to/in anticipation of stressors; whilst stressors are being experienced; and following stressors or in relation to changes in their health and well-being).

The findings in the qualitative and the cross-sectional studies reflect the discourse on resilience. Resilience refers to the ability to maintain one's mental health when exposed to stressors or other adversities[590] and describes a process of adjustment or adaptation[591]. Resilience is determined by personal characteristics (e.g. hardiness, biological factors, exposure to adversity) as well as systemic factors (e.g. social support, family, culture, or community)[590, 592-594]. Consistent with previous research on resilience, control (e.g.

disempowerment), social support (particularly functional support like emotional and instrumental support) or isolation, and chronic or cumulative exposure to stressors were all found to impact on women's mental health, and should thus be considered in relation to their implications for women's resilience[593, 594]. The literature on resilience further emphasises the impact of social determinants on health on resilience, for example marginalisation or a loss of access to coping resources (e.g. through migration or social exclusion)[591]. Consequently, policy and services should recognise that resilience may not only be contingent upon individual traits, and consider the implications of social determinants of health at the community level for resilience. Ultimately, policy and services should seek to promote resilience, for example by increasing access to community resources like social or religious groups, or identifying and seeking to address barriers to women's agency or control.

Thus, the qualitative findings supplemented the quantitative study by exploring some of these processes, and showed that the multiple events and processes women experience over their life course contribute to each other over time (reflecting the concept of stress proliferation [492] and intersectionality [229, 232, 442]), and intersect with systemic factors. For example, migrant women (particularly women without leave to remain) experienced barriers to work due to their migrant status. This impacted on their socio-economic status, resulting in further marginalisation [24, 47, 55, 88-90, 156]. This conceptualisation is valuable because it identifies the structural factors contributing to these processes, suggesting that interventions must thus be targeted at the systemic level and the individual level.

8.2 Strengths and limitations

8.2.1 Strengths

The use of mixed-methods strengthened the research by enabling me to identify patterns at the population level using cross-sectional data from the SELCoH survey for a large representative sample of women living in South East London, and to gain insight into the perspectives of women in London through in-depth interviews. The in-depth interviews also enabled me to provide a temporal context to women's experiences and changes in their mental health and well-being. This life-course approach allowed me to examine the

interrelationship between women's experiences at different life stages and their mental health, and to gain information about the periods leading up to, during, and following migration, which supplemented the cross-sectional data.

A diverse sample of migrant women and women born in the UK were represented in the quantitative and qualitative studies, including non-English speaking participants, enabling the inclusion of migrant and ethnic minority populations who are often not represented in research [287, 290, 293, 294]. The two studies also provided findings specific to these communities in London, which is important for informing locally relevant policy and services [372].

8.2.2 Limitations

While this study provides insight into the mental health needs of migrant women and women born in the UK living in London, the findings may not be generalisable to other populations in the UK or internationally. In addition, though the study included a diverse sample of women in London, including non-English speaking participants, certain communities may not be represented. For example, although strategies were in place to minimise these barriers (as described in chapter 3 section 3.2.2, page 93, and chapter 5 sections 5.3.2.1, page 172 and 5.3.3.4.2, page 180), women still may not have elected to participate due to socio-cultural barriers, language barriers, fear or mistrust relating to their participation in research, or health barriers. Furthermore, the women represented in the quantitative and qualitative studies were either living in private accommodation or were in contact with community organisations; their views and experiences may not be representative of women who do not fall into these groups (e.g. women who are more isolated, women who are detained, or more mobile populations).

8.3 Implications for policy and services

This PhD utilised an ecosystemic framework to examine the factors impacting on women's mental health at multiple levels. The implications of the findings for policy and services are therefore also discussed in relation to an ecosystemic framework, as they point to the

need for a systems approach which addresses the mental health and social needs of both migrant women and women born in the UK at the macro, meso, and micro level.

8.3.1 Macro-level

Women's experiences of marginalisation (e.g. due to their socio-economic status, gender, migrant status, or ethnicity) presented barriers to their access to care and the quality of care they received. Inequalities in care due to these marginalised statuses have also been identified in other research. For example, in the GP Patient Survey 2013 and the 2012 Adult Inpatient Survey it was identified that white British patients had higher levels of confidence and trust in their GP, and overall satisfaction compared with minority ethnic groups[595-597].

As stipulated in the Equality Act 2010 and the Health and Social Care Act 2012, the NHS is legally obligated to promote equality and actively seek to address health inequalities[597-599]. These recent data, collected after the Equality Act was enacted, and the findings in this study point to the continuing need to tackle inequalities based on marginalised statuses in health services.

This can be pursued at a systemic level by: monitoring the performance of the NHS; identifying vulnerable populations or communities experiencing health inequalities; collaborating with stakeholders at the micro, meso, and macro levels to identify inequalities and strategies to promote equality; integrating care and services to address gaps in access to and quality of care; and allocating resources and incentivising and prioritising improvements in care for marginalised populations[597]. The mandate from the Government to the NHS Commission Board (April 2013 to March 2015) prioritises the obligation to reduce health inequalities, and emphasises the responsibilities of the public health and social care system, as well as policymakers to increase equality in health, and may assist in achieving the recommendations above[600]. Overall, however, it may be challenging to address inequalities given the current economic climate and the spending cuts over the last three years, particularly for the NHS, which is expected to make savings of £20 billion by 2015[601].

The health system should also seek to prioritise evidence based programmes of work to meet the legal obligations stipulated in the Health and Social Care Act and the Equality Act[597]. In order to ensure that inequalities in care are identified and that programmes of work are effective, it will also be valuable to increase the data available relating to health inequalities and the provision of care, and to ensure that this information is disseminated to or available to policymakers and providers. This may be significantly improved by the National Equality and Health Inequalities data group, which is in the process of being established[597].

In addition to these efforts to ensure equal access to and the quality of health care, it is also important to examine other macro-level factors that may be putting women in London at risk of experiencing psychological symptoms or which may present barriers to accessing health and/or social care. This is particularly relevant given the policy changes that have occurred during the time in which this study was conducted, and which are continuing to affect women. For example, the Labour Party (commissioned by the House of Commons), the Institute for Fiscal Studies (Fawcett Society), and the Women's Budget Group (Landman Economics) have identified gender disparities in the impact of the benefit and tax changes since 2010 and, indeed, after the 2013 budget, and that overall women have been disproportionately affected, in particular, single women, female pensioners, and female lone parents[602].

Research has also suggested that there are inequalities in the impact of spending cuts by ethnicity. In an assessment of the human rights and equality impact of the public spending cuts on Black, Asian, and Minority Ethnic (BAME) women in Coventry, it was suggested that these populations have been disproportionately affected due to: public sector job cuts in which BAME women are more likely to be employed than white women or BAME men; cuts to housing benefit, where a higher proportion of households in BAME communities are on low income than other ethnic groups; welfare benefits and tax credits, where BAME women are more likely to have a low socio-economic status, larger families, and receive benefits than other communities; cuts to interpretation and translation services; and cuts in spending on education, which may disproportionately affect ethnic minority communities

requiring language training, and families receiving the Education Maintenance Allowance, who are disproportionately BAME families[601]. Though women may be disproportionately affected because they are more likely to be in the groups more affected (e.g. single parents or pensioners), it still suggests that the support needs for these communities, and consequently the burden on 3rd or voluntary sector groups may have increased since 2010.

There are several factors at the macro-level that could be addressed to help reduce the structural barriers in the migration system described in the qualitative narratives. For example, efforts should be made (e.g. by the UK Border Agency) to ensure sufficient information regarding the immigration system and migrants' rights or resources is available and accessible to migrants and to organisations supporting these communities. In the narratives, women also identified stressors associated with immigration processes. The data from the cross-sectional survey also indicated that individuals who migrate for asylum or other political reasons may be at increased risk of experiencing high levels of psychological symptoms compared with other migrants, after controlling for exposure to stressful life events and other migration specific factors. Though it wasn't possible to ascertain why this group was at increased risk from the data, it may be that factors associated with the process of seeking asylum in the UK contributed to their risk. These findings suggest that it may be beneficial to review the immigration process and identify and address structural factors that may be increasing migrants' risk of experiencing psychological symptoms. Based on the experiences women described in the qualitative interviews, for example, this could include: reducing waiting times for decision on applications (e.g. for asylum); increasing the support and training provided to case workers, and facilitating the cooperation of case workers, legal representatives, and asylum seekers; decreasing the number or length of interviews and determine applicants' preferences for the background of their interviewers/interpreters for these interviews (e.g. female, from same or different cultural background; see guidelines in chapter 2, section 2.4.1 and Table 2, page 81); ensuring immigration processes (e.g. asylum interviews) are not coercive or oppressive; and implementing guidelines for conducting sensitive research in such interviews, particularly given the focus in such interviews on stressful life events, and the

potential vulnerability or mental health needs of migrants (see chapter 5, section 5.3.3.6, page 181, and Renzetti and Lee (1993)).

It is also important to contextualise migrants' interviews and applications in relation to exposure to stressors (e.g. trauma), for example acknowledging the potential impact immigration processes (e.g. interviews) and revisiting previous traumas may have on their mental health [558, 559], or the potential implications exposure to trauma may have for their mental health and ability to make cohesive applications [547, 548, 555-557]. In addition, case workers, immigration judges, and other stakeholders should receive training relating to these issues [603], and applicants should be afforded the opportunity to supplement their applications (e.g. with further explanations or relevant materials), particularly where there are seen to be inconsistencies in their applications which may be related to factors like exposure to trauma and cognitive disruption. This may involve accommodating delays in decisions [603].

The research also highlights the need to limit policies contributing to the disempowerment of migrant women during the immigration process. For example, in the narratives, asylum seeking women spoke about the disempowerment they experienced in relation to restrictions on their right to work, and the consequences this had for their socio-economic status and ability to settle. In the literature, policies restricting asylum seekers' right to work have also been criticised [63, 107, 272]. Such policies limit this community's ability to integrate or access social resources, or to improve their financial circumstances and skills, and compromise their agency and sense of self-worth; furthermore, it has been asserted that such policies are not in line with the Universal Declaration of Human Rights [513]. Asylum seekers in the UK who are 'destitute' can receive cash support, though it equates to £5.23 per day for food, sanitation and clothing [179]. Housing may also be provided, however asylum seekers have no choice regarding where it is or the quality of it, and housing is not provided in London [179]; this may be particularly challenging for asylum seeking women in London who are experiencing abuse, particularly if they have children, and as highlighted in the cross-sectional survey and the qualitative interviews, women in London experience

high rates of violence. Policy changes, such as granting asylum seekers temporary work permits or increasing their financial support, may have significant benefits.

Such changes may also be beneficial for dependants (e.g. women whose migrant status is dependent on their partners or family members) who are experiencing abuse. A lack of financial resources (e.g. no recourse to public funds, or restrictions on paid employment) may limit their ability to leave abusive relationships [125, 506]; women's lack of access to safe accommodation (e.g. refuges) or financial support for themselves (and potentially their children), due to a lack of access to public funds and restrictions on their ability to work, has been criticised for increasing their vulnerability [125, 506]. Other policies, for example the evidential requirements of the Domestic Violence Rule, may also prevent women from leaving abusive situations or successfully demonstrating their exposure to abuse in their application for Indefinite Leave to Remain; there are numerous barriers to reporting abuse for these women, and a lack of consistency in services' records of abuse and their responses to disclosures of abuse [125, 506].

Policies limiting women's ability to leave abusive relationships (and consequently restricting their agency and compromising their safety) have been criticised by previous authors [157, 165, 500, 504-506], and efforts have consequently been made in immigration policy to address these concerns [506], though these help only a very limited number of women. However, these concerns were identified in the qualitative study, suggesting they continue to impact on migrant women in the UK and thus further steps are needed to address them. Policy makers should consider modifying or reducing the evidential requirements for women who have experienced abuse, providing additional training to service providers about domestic violence and legal policies relevant to migrant women, improving the effectiveness of services responsible for identifying and/or recording women's exposure to abuse, and increasing outreach and the distribution of information about services and entitlements to migrant women. Additional resources could also be provided to women to facilitate their ability to leave abusive situations or to enable their independence if they do leave such situations. For example, policy makers should consider granting more migrant

women without leave to remain temporary work permits, increased financial support or access to public funds, and access to safe housing (for them and their children) [125, 506].

It is also important to consider the situations of women born in the UK experiencing abuse, as it was evident in this research that both migrant women and women born in the UK experienced high rates of violence. Women who have experienced violence may be disproportionately affected by the spending cuts due to loss of funding for community support services and voluntary organisations (e.g. due to cuts in local and national funding streams), and cuts to the police and Crown Prosecution Service, to legal aid, and to welfare benefits (e.g. housing benefit)[601]. Thus, it is essential that policy and services collaborate to ensure that there are accessible services for women who have experienced violence, and that women do not experience unequal access to health or social services due to marginalised statuses (e.g. socio-economic status, ethnicity, or migrant status).

8.3.2 Meso-level

At the community level, particularly in boroughs with diverse populations of women, community organisations and services must have detailed knowledge of the rights of and resources available to women. In particular, organisations and services should be aware of and receive training relating to specific topics, for example issues affecting migrant groups, or abuse [496, 604-606]. Such training will help to ensure that community organisations and services are able to provide relevant information, that women's entitlements are acknowledged and respected by these organisations, and that organisations and services can be responsive in providing resources appropriate to women's needs (which may pertain to a range of social and health needs: intimate partner violence, health, legal support, employment, language training, housing etc.) [496, 607]. The training and preparedness of providers and gatekeepers across sectors on these topics is important as women may not know what their rights or entitlements are as migrants, or may not specifically seek support for domestic violence, so their contact with social, legal, or health services may be the only opportunities for abuse to be identified or disclosed [608]. Across such services, there should be collaboration to holistically address the range of social and health needs these communities may require, and to ensure the support women receive is appropriate,

cohesive, and integrated (a 'joined-up care' or interagency approach, rather than addressing each need in isolation) [604, 609, 610]. Programmes or interventions at the community level would also benefit from the involvement of a range of stakeholders in their development, including service providers, gatekeepers at community organisations, members of the public, and the target group [496, 609]. In particular, the involvement of target groups in the identification of community needs, and appropriate and acceptable strategies to address these needs, may benefit the acceptability and efficacy of programmes or interventions [610].

Advocacy or outreach services may also be beneficial to help women access relevant information, and navigate the systems and services in the UK [272, 321, 610, 611]. In addition, such services may be helpful in addressing the isolation that some women experience. The need for advocacy and outreach services is supported by the literature. For example, in in-depth interviews with 21 refugees and asylum seekers engaging with a refugee centre in London, Palmer and Ward identified that these individuals perceived there was a need for more advice centres and community centres, as well as more outreach work by these centres or health visitors in the community in order to adequately inform and engage the migrant community [321]. Training or education programmes should also be offered to the public to increase community awareness and to help address barriers to women's access to services. This may include, for example, anti-stigma and discrimination campaigns, or public education [496, 609, 612].

8.3.3 Individual level

A focus on individual level factors can help facilitate the identification of appropriate and effective care or interventions. Multiple factors may be contributing to women's mental health needs, and service providers should seek to identify and address the range of social and health needs of the individual [612]. For example, when assessing a woman's mental health needs, it may be valuable for providers to contextualise these needs in relation to their experiences (e.g. trauma or abuse), and for efforts to be made to address social needs relevant to these experiences where possible in addition to women's mental health needs [272]. It is important to determine whether enquiries into these factors (e.g. abuse) are

acceptable to the individual, and there is evidence that routine enquiry into domestic violence in mental health and primary care settings is acceptable to women [613, 614].

In addition to the impact of stressful life events on mental health identified in the cross-sectional survey and the in-depth interviews, the cross-sectional survey highlighted the increased risk of experiencing high levels of psychological symptoms among individuals with a long standing physical condition. The co-occurrence of mental and physical ill health in this population has also been identified elsewhere[615]. When addressing an the mental health needs in this community, stakeholders at the macro, meso, and micro levels will need to be aware of the impact that poor physical health can have on mental health, the barriers it may present to accessing services, and the implications it has for the treatment received. At the individual level, a patient's mental health needs cannot be addressed in isolation as it is evident that there is a high risk for comorbidity.

Watters suggests that care or treatment should be informed by a Maslowian hierarchy of needs, attending to an individual's physiological or safety needs, not only their mental health needs [272]. In order to identify needs, providers should seek to identify women's perceptions of their needs. My findings suggest that the diverse population of women in London may have significant mental health needs, but that in order to address these needs, services must be able to accommodate individuals with limited English proficiency, unfamiliarity with biomedical terminology, or differing illness models. This can help to improve the acceptability of care, the effectiveness of and adherence to treatment, and enable the patient to articulate her own needs and be actively involved in her treatment and care decisions [605].

It is also important that accessibility is considered at the individual level, for example adapting the delivery of services based on the language, literacy, legal status, and socio-cultural background (e.g. religious requirements, socio-cultural practices, or illness models) of the individual. For example, services should ensure interpreting services or translated materials are available [605, 610]. In their in-depth interviews with 21 asylum seekers and refugees, Palmer and Ward identified that this group felt health services could be improved by having information (e.g. letters or questionnaires) and the provision of services (e.g.

interpreters) available in a range of appropriate languages or by having staff from their own community. Language presented not only a barrier to the accessibility and provision of care, but also resulted in a lack of awareness of available care among migrant communities [321].

The guidelines for cross-language methods presented in chapter 2 (see Table 2, page 82), are relevant to and should be implemented by services where translation or interpretation is needed. Such resources (e.g. interpreters or translation) must also be free, and easily and quickly organised. In addition, staff (e.g. health workers) must be adequately trained to work with these resources (e.g. conducting clinical assessments with interpreters) [31]. These factors may impact on women's help-seeking, interactions with services (including the disclosure of certain needs, for example in relation to abuse), the assessment of their needs, and the acceptability of treatments.

The mandate from the Government to the NHS Commissioning Board (April 2013 to March 2015) also supports the need for services to be more responsive to individual needs, and for the individual to have a role in directing the care they receive. The mandate promotes the objective of increasing patients' choice in the NHS, including helping individuals to choose services that are appropriate (e.g. due to religious needs), and to enable individuals to choose the services they receive (rather than these services being chosen for them). However, it is also important to recognise that the ability to 'choose' services is contingent upon individuals' access to care, agency, and knowledge of the health system. Individuals who experience processes like the marginalisation, disempowerment, or isolation identified in the in-depth interviews may, thus, have unequal opportunity to choose the care they receive, and consequently inequalities in access to and the quality of care will persist. In order to address this, services at the macro and meso level should seek to increase the provision of information and support to individuals who may face barriers to accessing services[600].

When developing interventions or individual care plans, it may also be beneficial to integrate the coping resources women utilise, or to develop strategies to increase women's access to coping resources. Research has also shown that health interventions focused on

empowerment are beneficial both as promoters of health and in helping women to cope with or address risk factors (e.g. abuse) [529, 530].

8.4 Recommendations for future research

Most research in this area is retrospective, and longitudinal research is needed to provide more insight into the effects of migration on mental health. Specifically, data on socio-demographic or socio-economic characteristics, exposure to risk factors, and psychological symptoms prior to, during, and following migration are needed. However, such data are difficult to acquire (e.g. due to limited research capabilities or records in migrants' countries of origin, challenges of collecting data for individuals prior to the decision to migrate, and barriers to follow up during and following migration). In order to conduct such research, strategies to acquire information about migrant populations would have to be developed (e.g. gaining access to records from immigration authorities in host countries), and contact with participants would have to be frequent in order to improve follow up rates. Such strategies have been used in research with other mobile populations (e.g. homeless populations)[614, 616].

Further research is also needed on the effects of processes of marginalisation, disempowerment, and isolation. For example, future studies should seek to collect data on marginalisation (e.g. enquire about whether an individual perceives they have experienced barriers to accessing support resources due to gender, socio-economic status, ethnicity, or migrant status) or disempowerment (e.g. level of choice in women's decision to migrate) in addition to socio-demographic characteristics or reason for migration, to examine their effects on psychological symptoms. Such research could also provide more insight into what aspects of the immigration process may put women at increased risk. More data on processes involved in resilience are also needed, as is further research into effective coping resources to inform the development of further strategies to enable women's coping and resilience.

In addition to the recommendations for specific areas of research, I have identified several methodological recommendations during the course of this study. Rigorous cross-language

methods should be utilised in cross-language qualitative research to improve validity and trustworthiness (see chapter 2, page 50). Some of the guidelines identified in chapter 2, for example the need to identify participants' preferences for the language and dialect in which research is conducted and the background of researchers, are also relevant to studies using quantitative methods. Both qualitative and quantitative studies should aim to include non-English speaking populations, where the findings may be relevant to these communities, as these populations are often excluded from research [292]. In addition, population surveys should endeavour to provide more consistent information regarding migrant status to improve the quantity and consistency of data on migrant populations [31, 583].

Research may also benefit from involving stakeholders, including members of the communities from which participants are drawn as well as service providers, throughout the research process (e.g. identification of aims, development, data collection, analysis, and dissemination) [320, 330, 609, 617]. It is also important that the research undertaken has goals which benefit participants (see chapter 5, section 5.3.3.6, page 181) [610].

In addition to these methodological recommendations, it is also important that research is conducted which both assesses the effectiveness of these recommendations (e.g. cross-language qualitative research methods), as well as the impact of interventions or changes in policy or services on the mental health of migrant women. There is a lack of research on the effectiveness of mental health services or health promotion interventions in migrant communities [583], and there is a very limited evidence base for changes in policy or practice to address migrant communities' needs [31].

8.5 Conclusion

There was no significant difference in the risk of experiencing high levels of psychological symptoms among migrant women and women born in the UK living in London. Both groups of women were found to experience high levels of psychological symptoms. Migrant women and women born in the UK were also found to experience high rates of long standing physical conditions and exposure to stressful life events. In particular, the research highlights the impact that exposure to stressful life events has on the mental health

and well-being of migrant women and women born in the UK, and in particular the salience and pervasiveness of abuse. The findings also suggest that women are subjected to processes of marginalisation, disempowerment, and isolation at the micro, meso, and macro-level due to their gender, socio-economic status, ethnicity, and migrant status, which often intersect. These processes contribute to women's exposure to stressors and changes in their mental health and well-being, and present barriers to accessing support resources. The research also identified coping resources that were protective and enabled women to address their social and health needs.

Women's mental health and social needs extend beyond their need for health services, as they limit women's quality of life and functioning, and their ability to seek social or economic opportunities, integrate, or access support resources [14]. In order to address the social and health needs of both migrant women and women born in the UK, and the multiple barriers they face to accessing coping resources or care, a systems level approach is needed. Policy and services must seek to reduce women's exposure to risk factors, increase their access to coping resources, and take into consideration their perceptions of their needs. Furthermore, such efforts must be preventative, accessible, and acceptable, and seek to address both health inequalities as well as the social determinants of health, which often intersect [607]. This may be facilitated through the collaboration and cooperation of stakeholders at the micro, meso, and macro-level [272, 610].

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Appendix 1: Search terms for chapter 1

1.1 Key words:

- depress*, PTSD, anxiety, common mental disorder*, Post Traumatic Stress Disorder, emotional disorder*, mood disorder*, mental disorder*
- refugee*, migrant*, immigrant*, asylum seeker*, migrat*, immigrat*
- UK, United Kingdom, Britain, England, Scotland, Wales, Ireland

1.2 Search of databases

The following searches were conducted in the electronic databases using the keywords above and mesh headings relevant to each data base:

1.1.1 MEDLINE

Keywords: Refugee* OR migrant* OR immigrant* OR asylum seeker* OR migrat* OR immigrat*

OR

Mesh headings: Refugees OR emigration and immigration OR transients and migrants OR emigrants and immigrants

AND

Keywords: Depress* OR PTSD OR anxiety OR post traumatic stress disorder OR emotional disorder* OR mood disorder* OR mental disorder*

OR

Mesh headings: stress disorders, Post-Traumatic OR anxiety OR anxiety disorders OR mental disorders OR depressive disorder OR affective symptoms OR mood disorders OR depression

AND

Keywords: UK OR United Kingdom OR Britain OR England OR Scotland OR Wales OR Ireland

OR

Mesh headings: Great Britain OR England OR Scotland OR Wales OR Ireland OR Northern Ireland

1.1.2 PsycINFO

Keywords: Refugee* OR migrant* OR immigrant* OR asylum seeker* OR migrat* OR immigrat*

OR

Mesh headings: Refugees OR immigration OR human migration OR migrant farm workers

AND

Keywords: Depress* OR PTSD OR anxiety OR post traumatic stress disorder OR emotional disorder* OR mood disorder* OR mental disorder*

OR

Mesh headings: Posttraumatic stress disorder OR anxiety OR anxiety disorders OR generalized anxiety disorder OR mental disorder OR affective disorders OR major depression OR mental disorders OR depression (emotion)

AND

Keywords: UK OR United Kingdom OR Britain OR England OR Scotland OR Wales OR Ireland

1.1.3 EMBASE Classic + EMBASE

Keywords: Refugee* OR migrant* OR immigrant* OR asylum seeker* OR migrat* OR immigrat*

OR

Mesh headings: Refugee OR migration OR long distance migrant OR migrant worker OR immigrant OR immigration

AND

Keywords: Depress* OR PTSD OR anxiety OR post traumatic stress disorder OR emotional disorder* OR mood disorder* OR mental disorder*

OR

Mesh headings: depression OR posttraumatic stress disorder OR anxiety OR anxiety disorder OR generalized anxiety disorder OR mixed anxiety and depression OR mental disease OR emotional disorder OR mood disorder OR major depression

AND

Keywords: UK OR United Kingdom OR Britain OR England OR Scotland OR Wales OR Ireland

OR

Mesh headings: United Kingdom OR Ireland

1.1.4 Sociological Abstracts (CSA)

Keywords: Refugee* OR migrant* OR immigrant* OR asylum seeker* OR migrat* OR immigrat*

AND

Keywords: Depress* OR PTSD OR anxiety OR post traumatic stress disorder OR emotional disorder* OR mood disorder* OR mental disorder*

AND

Keywords: UK OR United Kingdom OR Britain OR England OR Scotland OR Wales OR Ireland

Appendix 2: Papers included in review on mental health of immigrants in the UK

Table 32 Papers included in review on mental health of immigrants in the UK (n=61)

Study design	Recruitment & Inclusion/exclusion criteria	Participants	Measures	Results	*Comments*
Bagley, 1971[193]					
Cross-sectional study.	Participants aged 15-64, in contact with psychiatric services between 1966-1968 identified from the Camberwell Psychiatric Register.	2086 participants born in the UK, 432 immigrant participants.	Clinical diagnoses	Period prevalence rate of mental illness: Britain: 14.68% Ireland: 23.67% India and Pakistan: 33.83% Caribbean: 16.60% Africa: 70.0% Cyprus and Malta: 9.9% Old Commonwealth: 69.23% Other foreign country: 19.10%	*Did not disaggregate by sex*
Baltas and Steptoe, 2000[262]					
Cross-sectional study.	Individuals born in Turkey who had been resident in UK for 2 years and married to British partner for 2 years; British partners. Identified from records of Turkish British Chamber of Commerce and Industry; Alumnus Association of Ankara High School.	33 Turkish participants (23 men and 10 women); 33 British partners of these immigrants (10 men and 23 women).	Beck Depression Inventory; State Trait Anxiety Inventory	BDI mean score: Turkish men and women: 4.13 (s.d. 3.1) and 4.40 (s.d. 2.8) respectively British men and women: 3.80 (s.d. 3.6) and 8.26 (s.d. 10.6) respectively. Trait Anxiety mean score: Turkish men and women: 31.8 (s.d. 5.4) and 34.1 (s.d. 7.8) respectively British men and women: 36.6 (s.d. 7.8) and 39.2	*Sample may not be representative of population of Turkish immigrants in the UK.*

				(s.d. 10.8) respectively. Depression scores higher among respondents with greater cultural conflict (marital cultural difficulties index).	
Bebbington et al, 1981[192]					
Cross-sectional study (Camberwell Psychiatric Register; population survey).	**Camberwell Psychiatric Register:** Participants aged 15-64, in contact with psychiatric services between 1970-1977. **Population survey:** Individuals aged 18-64 in Camberwell on electoral register.	**Camberwell Psychiatric Register**: Native-born, Irish-born, West Indian Born. **Population survey:** 40 item version of Present State Examination: 800 participants (611 British born, 69 West Indian or West Indian Origin, 32 Irish born, 88 other) Full Present State Examination: 310 participants (233 British, 31 West Indian or West Indian origin, 46 other)	**Camberwell Psychiatric Register**: Rates of new episodes, prevalence, and admissions (clinical diagnosis) **Population survey:** Present State Examination	**Camberwell Psychiatric Register**: Mean point prevalence per 100,000 of affective disorders 1970 – 1977: United Kingdom men and women: 172.7 and 417.9 respectively. West Indies men and women: 136.6 and 344.5 respectively. Ireland men and women: 227.8 and 490.6 respectively. **Population Survey:** 40 item Present State Examination, prevalence of disorders: Britain men and women: 8.8% and 18.1% respectively. West Indies men and women: 3.2% and 18.4% respectively. Full Present State Examination, prevalence	*'West Indian or West Indian origin' category may include individuals who were born in the UK.*

				of disorders: Britain men and women: 6.2% and 14.7% respectively. West Indies men and women: 0.0% and 10.9% respectively.	
Bhatnagar and Frank, 1997[196]					
Cross-sectional study.	Elderly individuals of Asian origin (no inclusion/exclusion criteria presented regarding age, country of origin). Random sample of patients of GPs in Bradford on Family Health Service Authority list with Asian names.	100 individuals of Asian origin (56% Indian, 36% Pakistani, 8% Bangladeshi)	Geriatric Mental State (GMS-A), clinical diagnosis (ICD-9 criteria).	GMS-A: Total prevalence of psychiatric disorders: 29% Depression: 20% Anxiety neurosis: 2% Clinical diagnosis: Total prevalence of psychiatric disorders: 28% (28% men, 27% women) Depression: 20% (20% men, 19% women) Anxiety neurosis: 4% (for men and women)	*This sampling method may not achieve a representative sample (e.g. women may not have Asian surnames if married to non-Asian individual; only recruited individual registered with GP).*
Bhatt et al, 1989[205]					
Cross-sectional study.	Aged 16 and over consulting five general practitioners in Manchester.	150 patients Country of birth: 54 UK, 28 India, 26 Pakistan, 21 East Africa, 11 Caribbean, 3 Ireland, 7 other Preferred	Symptom checklist; General Health Questionnaire; Illness Behaviour Questionnaire; Clinical assessment (by GP)	Gujarati speaking participants had fewer psychosocial complaints, less anxiety on symptom checklist and GHQ, were more likely to attribute symptoms to physical causes, and less likely to be regarded as suffering from mental disorders	*Analysis done according to language or preference; English speaking group does not necessarily denote born in the UK (e.g. 54 individuals born*

		language: 66 English 45 Gujarati 28 Urdu 5 Punjabi 2 Bengali 4 Other		compared to English or Urdu speaking groups group. Urdu group less likely to present psychosocial complaints, less anxiety on the GHQ than English speaking group, and more likely than Gujaratis to be assessed by GPs as having definite or possible mental disorders. GHQ: Anxiety median score (range): English: 1.5 (0-7) Gujarati: 0 (0-6) Urdu: 0 (0-6) Depression: English: 0 (0-7) Gujarati: 0 (0-5) Urdu: 0 (0-3)	*in the UK included in sample; 66 individuals identified English as preferred language).* *Did not disaggregate by sex.* *Data not provided on rates of disorders, only number of complaints, number of symptoms, etc*
Bhui et al, 2003[208]					
Cross-sectional study.	Somali immigrant on register of Somali people in Greenwich.	180 Somalis (91 men, 89 women)	Harvard Trauma Questionnaire, Symptoms and Complaints Questionnaire, Hopkins symptom checklist, Beck Depression Inventory, Brief Psychiatric Rating Schedule	One or more thoughts of killing self: Men (42.7%), women (27.27%) Anxiety and depression 75th quartile threshold score: Men (21.59%), women (27.91%) Psychosis (5 or more on any one item): Men	*Strength of study is that it disaggregated for sex for outcome measures as well as exposure to trauma.*

				(21.11%), women (17.98%). Exposure to trauma significantly associated with anxiety and depression (OR:1.31 [95% CI: 1.06 – 1.62]).	
Bhui et al, 2006[198]					
Cross-sectional study.	**Primary care register:** patients of Somali origin registered with Somali names. **Community sites:** recent immigrant to UK from Somalia for resettlement; of Black African ethnic group; resident in London boroughs of Tower Hamlets or Lambeth; duration of residence in UK: 0-5.5 years.	143 Somalis recruited from GP registers and community sites	MINI Neuropsychiatric interview: ICD-10 mental disorders	Prevalence of current major depression: 26.6% Prevalence of PTSD: 14% Increased risk of mental disorders among individuals who use khat (OR = 10.5 [95% CI: 1.1 – 98.3], claimed asylum at entry to UK (OR = 12.8 [95% CI: 2 – 81.4]) and or were recruited from primary care (OR = 5.9 [95% CI: 1.4 – 25.8]).	*Did not disaggregate by gender*
Bhui and Warfa, 2010[238]					
Cross-sectional study.	Somali immigrant on register of Somali people in Greenwich.	180 Somalis (91 men, 89 women)	Harvard Trauma Questionnaire, Symptoms and Complaints Questionnaire, Hopkins symptom checklist, Beck Depression Inventory, Brief Psychiatric Rating Schedule	Trauma increases risk of high levels of anxiety and depression (OR: 1.33 [95% CI: 1.13 – 1.56])	*Data on prevalence rates published in Bhui,2003.*

Bogic et al, 2012[236]					
Cross-sectional study.	Born in former Yugoslavia; aged 18-65; had experienced at least one war-related traumatic event; had experienced the final war-related event at or after 16 years of age; had no severe intellectual disability and no mental impairment. Recruited from community organisations and through snowball sampling.	854 war refugees across former Yugoslavia in Germany, Italy, and the UK (302 in UK, including 168 women and 134 men; 67.9% from Bosnia and Herzegovina)	Mini International Neuropsychiatric Interview (MINI); Life Stressor Checklist-Revised	Prevalence: Any mood disorder: 45.1% (S.E. 2.9). Any anxiety disorder: 42.4% (S.E. 2.8) (PTSD: 28.8% (S.E. 2.6)).	*Did not disaggregate by gender (for exposure to stressors or mental disorders).*
Bögner et al, 2007[186]					
Mixed-methods (Semi-structured interviews and cross-sectional study).	History of pre-migration trauma.	27 refugees and asylum seekers (17 from central London traumatic stress clinic; 10 from London based community services).	Semi-structured interviews (thematic analysis); PTSD symptom scale-interview (PSS-I) Hopkins Symptom Checklist-25 (HSCL-25) Experiences of Shame Scale (ESS) Peritraumatic Dissociative Experiences Questionnaire-Self-Report Version (PDEQ-SRV).	Difficulties in disclosing personal details in Home Office Interview due to shame, experiencing psychological symptoms; 20 participants reported first time they talked about traumatic pre-migration event was after arrival in the UK. Women with history of sexual violence reported more difficulties in disclosing information in interviews ($t(25)=4.91$, $p<0.001$); more experiences of shame	*Small sample for quantitative analysis.*

				(t(25)=4.10, p<0.01); more dissociative experiences (t(25)=2.84, p<0.05); and higher scores for PTSD (t(25)=2.46, p<0.05). PSS-I mean score (s.d.): Women w/ sexual violence: 37.7 (10.7) Women w/ no sexual violence: 27.1 (11.6). HSCL depression mean score (s.d.): Women w/sexual violence: 43.5 (11.4) Women w/ no sexual violence: 36.3 (10.7).	
Bradley and Tawfiq, 2006[194]					
Cross-sectional study; case study.	Kurdish asylum seekers from Turkey who were referred for medical evaluation of allegations of torture through legal practice in North London.	97 participants (83 men, 14 women)	Clinical assessment (DSM-IV criteria)	14% of patients had symptoms fulfilling criteria for PTSD. 7% fulfilled diagnostic criteria for a major depressive episode. 7% fulfilled diagnostic criteria for generalised anxiety disorder (without PTSD).	*Did not disaggregate by gender for outcome.*
Burke, 1976[201]					
Cross-sectional study.	Individuals aged 15 or over in records of general hospital admissions in Birmingham who	2,695 (278 Irish republic; 104 men, 174 women).	Attempted suicide (hospital records)	10% of attempted suicide cases in hospital register were from Irish Republic, who only comprised 4% of the general public.	*Compared native (in Ireland) and immigrant women.*

	attempted suicide between 1969-1972.			Average annual rate of admission of immigrants from Irish Republic probably higher than rates in Ireland (284 per 100,000 compared to 208), particularly for women (369 vs. 303).	
Burke, 1976[618]					
Cross-sectional study.	Individuals aged 15-64 or over in records of general hospital admissions in Birmingham who attempted suicide between 1969-1972.	62 individuals (28 women and 24 men) who attempted suicide by self-poisoning and were born in India, Pakistan, or Bangladesh.	Attempted suicide (hospital records and case notes).	Rate of attempted suicide per 100,000: Asian women: 126, Asian men 57. 33% of patients given psychiatric diagnosis (19.4% given diagnosis of depression).	*See Burke, 1976 above.*
Burke, 1979[202]					
Cross-sectional study.	Women aged 15-24 admitted to psychiatric unit in Trinidad and Tobago, or who were born in West Indian or East Indian country and admitted to general hospitals or accident hospital in Birmingham due to self-poisoning or self-injury.	96 women: 52 in Trinidad and Tobago, including 13 east Indian women and 39 West Indian women. 44 in Birmingham, including 16 East Indian women and 28 West Indian women.	Attempted suicide (hospital records and case notes).	Rate of attempted suicide per 100,000: Trinidad and Tobago: 96 Birmingham: 344 Trinidad and Tobago: Depression 31% Birmingham: Depression 21%	*See Burke, 1976 above.*
Burke, 1984[189]					
Cohort study.	Data from general practitioners during 5-year period.	243 West Indian patients, 682 British patients.	30 item General Health Questionnaire; Mental State Examination	West Indians had higher rates of possible psychosomatic illness (45.3% vs. 29.2%,	

	Cases: West Indians who had been registered during previous year as patients in a large group practice of general practitioners in Birmingham. Controls: British individuals who lived on same streets as the West Indians who had been registered at practice for 5 years.			p<0.000). Incidence of depression higher in West Indian population (17.3% vs. 10.9%, p<0.05). Incidence of depression: West Indian: males 14.1%, females 20.4%; British: males 8.3%, females 13.5%	
Carswell et al, 2011[195]					
Cross-sectional study.	Refugees, asylum seekers, or refused asylum seekers aged 18 or over recruited from NHS trauma clinic, outpatient psychology service, and refugee support agencies. Participants excluded if clinician believed involvement caused too much distress or if confidential interview not possible.	47 refugees and asylum seekers (27 men, 20 women).	Harvard Trauma Questionnaire; Hopkins Symptom Chechlist-25 (HSCL-25); demographic and post-migration living difficulty questionnaire; short form social support questionnaire (SSQ6); Duke-UNC Functional Social Support Questionnaire (Duke-UNC FSSQ).	81% of participants met caseness for PTSD; 96% reached caseness for major depressive disorder. Number of traumas associated with PTSD (r=0.49, p<0.000) and HSCL (r=0.46, p<0.001) Adaptation difficulties associated with PTSD (r=0.46, p≤0.001). Loss of culture and support associated with PTSD (r=0.49, p<0.000) and HSCL-25 (r=0.61, p<0.000).	

				Duke confidant inversely associated with PTSD (r=-0.40, p≤0.005).	
Cochrane and Bal, 1989[187]					
Cross-sectional study.	Individuals admitted to mental hospitals in England in 1981.	186,000 admissions	Clinical assessment for admitted patients	Rates of all admissions for males for depression, neuroses per 100,000: England: 79, 28 Ireland: 197, 62 Caribbean: 65, 6 India: 68, 22 Pakistan: 68, 19 Germany: 43, 10 Italy: 83, 25 USA: 38, 9 Kenya: 56, 19 Poland: 111, 28 Cyprus: 62, 15 Hong Kong: 12, 16 Rates of all admissions for females for depression, neuroses per 100,000: England: 166, 56 Ireland: 410, 111 Caribbean: 152, 25 India: 118, 27 Pakistan: 96, 47 Germany: 119, 47 Italy: 149, 42 USA: 103, 6 Kenya: 61, 21 Poland: 279, 75 Cyprus: 75, 24 Hong Kong: 75, 29	

Cochrane and Stopes-Roe, 1977[227]					
Cohort study.	Immigrant sample born in India or Pakistan (which included Bangladesh at that time) and of appropriate ethnic origin. Minimum age 20 years. British sample: born in UK, with parents from UK, white ethnicity, living in same area as Asian participants. Matched on age, sex, and area of residence.	50 Indian (28 men, 22 women) and 50 Pakistani (27 men, 13 women) residents in Birmingham; 100 British controls	Langner 22-item scale; Life Events Inventory.	Langner 22-item scale median scores: Indian: 2.93 Pakistani: 1.55 British 3.50 (Pakistani scored significantly lower than British, $p<0.01$). Pakistani males scored lower than British males (1.25 vs. 3.33, $p<0.01$). No significant differences between Indian or Pakistani women and British women.	*Compared immigrant and native populations of women.*
Cochrane and Stopes-Roe, 1981[619]					
Cohort study.	Aged 20-60 years. Indian immigrants (born in India and ethnically Indian) in London, Birmingham, Coventry, and Slough; British sample matched on age and sex. 'Random-walk' sampling.	200 Indian born participants 200 Pakistani born participants 240 British born participants; resident in large English cities.	Langner 22-Item Scale of Distress	Langner scores: British: 3.5 (male: 3.0, female: 4.5) Indian: 1.9 (male: 1.8, female 2.1) Pakistani: 3.2 (not disaggregated)	
Cochrane and Stopes-Roe, 1981[72]					
Cohort study.	Aged 20-60 years. Indian immigrants (born in India and ethnically	200 Indian (110 male, 90 female); 200 British (110	Langner 22-Item Scale of Distress; migration difficulty index;	Mean Langner scores (s.d.): Indian: male 1.72 (2.38),	*See Cochrane and Stopes-Roe, 1981 above.*

	Indian) in London, Birmingham, Coventry, and Slough; British sample matched on age and sex. 'Random-walk' sampling.	male, 90 female).	acculturation index.	female 2.07 (2.57) British: male 3.00 (3.30), female 4.45 (3.92). Social mobility negatively correlated with symptom levels for male Indians (-0.16, $p<0.05$) and positively correlated for female Indians (0.20, $p<0.05$). Age at migration positively correlated with symptom levels for male and female migrants (0.22 and 0.39 respectively, $p<0.001$). Years in England negatively correlated with symptom levels for male Indians (-0.17, $p<0.05$).	
Cohen and Cohen, 2008[209]					
Cross-sectional study.	Asylum seekers in detention centres and community who had self-harmed or attempted (or committed) suicide.	231 incidents of self-harm requiring medical treatment in immigration removal centres between 1/04/05 and 31/03/06; 38 suicide deaths of asylum seekers between January 2000 and December 2005 (35 male, 3 female).	Data from immigration removal centres, records of suicides in prison and immigration removal centres, coroners records and prisoner's ombudsman's reports.	Average population of these IRCs is 1806. Suicide rate per 100,000 asylum seekers in detention (prison or immigrant removal centres): 112.5 72% of individuals who committed suicide diagnosed with depression, 6% with PTSD.	*Did not disaggregate by gender for diagnoses or self-harm.*

Commander et al, 1999[620]					
Cross-sectional study.	Household survey of residents of West Birmingham Health District aged 16-64 registered with general practitioner accessing services over following 6 months.	2657 West Birmingham Health District residents used specialist mental health and addiction services during 6-month study period (179 white Irish born). 508 participants in household survey (24 born in Ireland)	Mental State Interview, structure Clinical Interview (DSM-III)	Morbidity rates per 1,000 for affective disorders for Irish-born 167 (95% CI: 47 – 374) vs. white 140 (95% CI: 97 – 180). OR: 1.0 (0.3 – 3.1).	
Djuretic et al, 2007[217]					
Qualitative study (focus group and semi-structured interviews).	Forced and elective migrants from the former Yugoslavia (asylum seekers, refugees, and migrants) recruited from Yugoslavian refugee organisations in London, local community café, and community centres.	19 participants (36% men, 64% women). 13 refugees, 6 'elective' migrants.	Focus groups with refugees and semi-structured interviews with 'elective' migrants; Thematic analysis	Impaired social functioning emphasised instead of emotional or psychological problems.	
Furnham and Li, 1993[267]					
Cross-sectional study.	First generation Chinese immigrants aged 19 or older who migrated to Britain from Hong Kong at age 18 or older. Second generation immigrants aged 18 or older of Chinese ethnic origin born in Britain or	70 (43 first generation, 27 second generation Chinese immigrants)	Langner 22-item Scale; Beck Depression Inventory	Langner 22-item Scale: 44.2% of 1st generation met cut off for distress, 22.2% of 2nd generation met cut off for distress ($t=1.58$, d.f. = 68, $p<0.01$). BDI scores:	*Did not disaggregate by gender.*

	immigrated to Britain prior to age 10. Recruited from London, Edinburgh, and the Midlands.			42.2% 1st generation met cut off for mildly or highly depressed, 22.2% 2nd generation met cut off for mildly or highly depressed.	
Furnham and Malik, 1994[224]					
Cohort study.	Middle-aged group: Born in UK or in India, Pakistan, or Bangladesh; aged 35-62. Young group: Born in the UK or received most of education in UK. Middle-aged subjects approach primarily through their children; majority of younger sample students at London University.	152 women (Middle aged group: 33 from UK, 33 from India, Pakistan, or Bangladesh; young group: 43 had British parents, 27 born in UK, 16 born in sub-continent).	Beliefs about Depression and Anti-Depressive Behaviour, Langner Symptom Scale	Asian middle-aged sample significantly higher mean score for Langner scale than British middle aged-sample (4.16 vs. 2.12) ($F(1,65)=8.09$, $p<0.01$)	*Compared immigrant and native women.*
Furnham and Shiekh, 1993[234]					
Cross-sectional study.	Aged 18 or older. Sample from central London and suburbs of greater London.	100 participants (56 women and 44 men). 65 born in India, Pakistan, Bangladesh, East Africa. 35 2nd generation immigrants (born in UK or migrated to UK before age of 10).	Langner 22-item scale; support networks	Female immigrants at increased risk of distress compared to male immigrants: Langner score (s.d.): 4.41 (3.61) vs. 3.14 (3.59) ($F(1,99)=5.04$, $p<0.02$)	
Gask et al, 2011[221]					

Qualitative study (in-depth interviews).	Women diagnosed as suffering from depression by general practitioner; prescribed antidepressant medication. Recruited from primary care practices in England.	15 women (3 born in UK, 11 born in Pakistan)	In-depth interviews (thematic analysis)	Key themes: 1) feeling stuck (persistence of depression inescapable); 2) Isolation; 3) control (loss of sense of control in depression.	
Griffiths, 2001[210]					
Qualitative study (semi-structured interviews).	Kurds in Greece in early phases of exile, Kurds in UK in later phases of exile, recruited from support organisations in each country.	25 Kurds in Greece in early phases of exile (16 men, 9 women), 20 Kurds in UK in later phases of exile (13 men, 7 women), 8 respondents from support organisations in each country (16 total).	Semi-structured interviews (content analysis)	Respondents in UK: 12 felt main difficulty they faced was being able to express themselves and be accepted. 18 perceived these difficulties more difficult for women (partly because imprisoned at home). Talking together is main source of support (20 respondents). 16 cited fear of authority. Perception that women were able to adjust more easily to new country; more able to support each other. Housing was prime difficulty.	
Guglani et al, 2000[142]					
Cross-sectional study.	Asian Hindu girls aged 13-17 enrolled at comprehensive	70 adolescent girls, and their mothers and	HADS and Rosenberg questionnaires	Grandmother's mental health mean scores (s.d.) by adolescent ethnic	

	secondary school in Redbridge who had been resident in Britain for at least 10 years; girls' mothers and grandmothers, who had to have been born in country of origin.	grandmothers.		identity group: **Anxiety** F=19.7, p<0.001: Asian/Indian: 4.3 (1.5) Hindi: 5.3 (1.4) British/English: 7.2 (1.9) **Depression** F =56.4, p<0.001: Asian/Indian: 5.3 (1.1) Hindu: 5.0 (1.1) British/English: 8.8 (1.8).	
Gupta et al, 2006[225]					
Cross-sectional study	Community based samples of peri and postmenopausal women aged 45-55 years from the Indian subcontinent living in Birmingham, Caucasian women living in Birmingham, and Asian women living in Delhi, India. Women in UK registered with 5 GP surgeries. Women in Delhi recruited through community contacts or were contacts of those participating in the study.	153 peri and postmenopausal women (52 Asian women from Indian subcontinent, 51 Caucasian women, 50 Asian women living in Delhi, India).	Women's Health Questionnaire; Menopause Representation Questionnaire.	Mean (s.d.) from WHQ: Depressed mood: Caucasian: 0.20 (0.24); Immigrant: 0.31 (0.27); Delhi 0.34 (0.31). p<0.031. Asian groups reported more emotional symptoms than Caucasian group.	
Hitch and Clegg, 1980[621]					
Cross-sectional study.	First admissions for psychiatric illness to a psychiatric bed from	1131 patients (971 UK, 101 New Commonwealth,	Patient medical files (diagnoses, sources and modes of referral)	Places per 100,000 for affective disorders (sample figures):	

	January 1968 – December 1970 for persons aged 16-64 resident in Borough of Bradford, Yorkshire.	59 Foreign born)		Born in UK: Male 61 (132), female 167 (398) Born in New Commonwealth: Male 39 (12), female 117 (20) Foreign: Male 102 (10), female 182 (15). Women from UK significantly more likely than women from new commonwealth to be admitted for affective disorders (X^2=14.12, p<0.001).	
Huang et al, 2006[216]					
Mixed-methods (Cross-sectional survey; Qualitative study using in-depth interviews).	Quantitative: convenience sample from clinics, churches, communities in the Birmingham area.	**Quantitative:** 113 participants (67 women, 46 men; 2 born in UK) **Qualitative:** 24 participants (11 women and 13 men; 7 from mainland china, 3 from Hong Kong, 6 from Malaysia, 7 from Taiwan)	General Health Questionnaire (GHQ)	61.4% of subjects met cut off for caseness in GHQ (38 women (66.7%) and 23 men (54.8%). Qualitative suggested for individuals in catering psychological adjustment heavily dependent on ties with Chinese community, whereas for professionals, conflict experienced as result of perceived need for integration.	*Did not disaggregate by migrant status in the quantitative (2 participants were born in the UK).*
Hunter et al, 2008[203]					
Mixed-methods study (cross-sectional study and semi-	Women aged 45-55 years. Asian women from	153 participants (52 immigrant women, 51 Caucasian women,	Perception of general health; perception of life satisfaction; Women's Health	Prevalence of reported depression highest in first generation Asian immigrants (42% self-	*It is feasible that the UK Caucasian sample could*

structured interview).	Indian subcontinent living in Birmingham, UK; Caucasian women living in Birmingham, UK; Asian women living in Delhi, India. Women in UK identified from records of 5 general practitioners. Delhi sample matched to sample of Asian women in UK (occupation, marital status, educational level). Women with history of severe, physically disabling medical or surgical conditions excluded, as were women with history/diagnosis of dementia, major current psychotic or affective disorders. Incomplete interviews also excluded.	50 Indian women in Delhi).	Questionnaire; open ended questions.	report, 42% Women's Health Questionnaire); similar to women in Delhi (36% self-report, 38% WHQ), and greater than UK Caucasian population (27% self-report, 20% WHQ). Depressed mood and life satisfaction significantly associated in all three groups. Depressed mood also associated with unemployment and poor general health. Immigrant women may not receive treatment in line with needs or values.	*have included women who were not born in the UK (does not stipulate if all born in UK).*
Hunter et al, 2009[200]					
Mixed-methods (Cross-sectional study; qualitative study using semi-structured interviews).	Aged 45-55 years; peri and postmenopausal. Women with history of severe, physically disabling medical or surgical conditions, or a history of dementia,	153 peri- and postmenopausal women (52 Asian immigrant women, 51 UK Caucasian women, and 50 Asian women living in Delhi).	Women's Health Questionnaire (WHQ); open ended questions.	For women from Delhi, depressed mood significantly associated with vasomotor symptoms (r=0.30, p<0.007). For UK Asian sample, anxiety (r=0.42, p<0.002) and depressed	*See Hunter et al, 2008.* *Didn't provide rates of anxiety or depression.*

	major psychotic, or affective disorders excluded). Asian immigrant women in UK (records from 5 general practitioners in Birmingham); Delhi sample from community leaders and contacts of UK participants; attempted to match with UK Asian sample.			mood (r=0.28, p<0.04) associated with vasomotor symptoms.	
Husain et al, 1997[204]					
Cross-sectional study (two phase).	Patients of Pakistani origin aged 16-64 who visited general practice in Manchester. Individuals who scored highly on PHQ and random selection of low scorers invited to be interviewed.	218 PHQs completed; 46 high scorers, and 31 low scorers interviewed (cases: 10 men, 34 women; non-cases: 11 men, 22 women).	Personal Health Questionnaire (PHQ); at interview, Psychiatric Assessment Schedule used; life event and difficulty schedule.	35 (80%) of cases born in Pakistan; 24 (73%) non-cases born in Pakistan.	*Little exploration of differences between immigrant and non-immigrant group; most of data not disaggregated.*
Husain et al, 2007[622]					
Cross-sectional study (two phase).	Patients of Pakistani origin aged 16-64 who visited general practice in Manchester. Individuals who scored highly on PHQ and random selection of low scorers invited to be interviewed.	218 PHQs completed; 46 high scorers, and 31 low scorers interviewed (cases: 10 men, 34 women; non-cases: 11 men, 22 women).	Personal Health Questionnaire (PHQ); at interview, Psychiatric Assessment Schedule used; life event and difficulty schedule.	35 (80%) of cases born in Pakistan; 24 (73%) non-cases born in Pakistan.	*Little exploration of differences between immigrant and non-immigrant group; most of data not disaggregated.*
Jayaweera and Quigley, 2010[235]					

Cross-sectional study.	Data from Millennium Cohort Study: Sweep 1 (2001-2002) when infants were 9 months old; data on date of arrival in UK from sweep 2.	17,258 biological mothers (2,327 born abroad)	Malaise inventory score (score of 4 or higher for depression/anxiety)	13.4% women in UK met cut-off for depression compared to 15.0% of women born abroad (AOR: 0.79 [95% CI: 0.62 – 1.00]) (adjusted for ethnic group, parity, age, education, occupational class, ward type, lone parent). Length of residence in UK associated with depression (AOR: 1.28 [95% CI: 1.07 – 1.53]).	
Johnson et al, 2009[199]					
Qualitative study (semi-structured interviews).	Non-Western interpreters who were survivors of trauma, no long-standing or debilitating distress following their trauma. Recruited from large interpreting service in Northern England. Participants excluded if had used Western mental health services or received any psychological treatment in the West.	9 interpreters (6 male, 3 female)	Semi-structured interviews (interpretative phenomenological analysis)	Key themes: trauma and wider shared oppression, resisting and responding, cultural protection and growth.	
Krause et al, 1990[206]					
Cross-sectional study.	Patients aged 15 and over of British birth and origin or of Punjabi origin	282 patients (141 first generation Punjabis, 29	General Health Questionnaire	52.5% of Punjab-born Punjabi met cut-off for case on GHQ (no	

	(with Punjabi identity and proficient in Punjabi); patients attending two health centres in Bedford.	Punjabis born in UK, 112 white British).		significant difference compared with British or British-born Punjabis). 45.1% of male Punjabis, and 60.2% of female Punjabis met the cut off.	
Leavey et al, 2007[237]					
Qualitative study (in-depth interviews).	Previous participants in case-control study; Irish born aged 18 years or older from records of general practices in North London – diagnosis based on Beck Depression Inventory.	40 participants (19 men, 21 women); 25 were identified as depressed.	In-depth interview (thematic analysis).	Themes relating to 'escapers' (traumatic or abuses experiences, oppression, vulnerabilities to depression) and to 'adventurers' (no difficulties with home life and pre-migration, but post-migration detrimental lifestyle), and non-depressed migrants who had resilience (clear sense of purpose, strong family connections). Post-migration vulnerability related to serious life events (e.g. domestic violence, illness, bereavement), and disconnection and poor social support.	
Lindesay et al, 1997[623]					
Cross-sectional study.	Aged 65 or older living in Leicester, sampled from Leicestershire District Family Health Service	150 Hindu Gujaratis, 152 whites	Mini-Mental State Examination (MMSE), depression scale of Comprehensive	Asian Gujaratis more likely to score lower on the MMSE than white British (median scores	*Did not disaggregate by gender.*

	Authority list.		Assessment and Referral Evaluation schedule (CARE-D), Phobic Disorders Screen (PDS).	(interquartile range): 22 (19-25) and 25 (23-27) respectively, p<0.0001). No differences found in levels of depression (2 (0.5 – 6.0) vs. 2 (0.5 – 5.0)).	*While the majority of the elderly Hindu Gujaratis were likely not born in the UK, this is not stipulated in the paper.*
Livingston et al, 2001[218]					
Cross-sectional study.	People aged 65 or older randomly selected from households in Islington, North London.	1085 participants (644 women, 441 men); 667 born in UK.	Comprehensive Assessment and Referral Evaluation (short-CARE).	Depression: UK 18.0% Ireland 16.5% Cyprus 28.2% (OR: 1.75 [95% CI: 1.03 – 3.11) Africa/Caribbean 14.3% Europe 18.3% Other 22.0%	*Didn't compare levels of depression between men and women, or between women born in UK and immigrant women.*
Livingston et al, 2002[207]					
Cross-sectional study.	People aged 65 or older randomly selected from households in Islington, North London.	1085 participants (644 women, 441 men); 666 born in UK.	Comprehensive Assessment and Referral Evaluation (short-CARE).	Depression: UK 18.0% Ireland 16.5% Cyprus, Greece, or Turkey 27.8% (OR: 1.54 [95% CI: 1.03 – 2.31) Africa/Caribbean 14.3% Europe 18.3% Other 22.0%. Greek, Turkish, and Cypriot migrants more likely to have GP visit, use out-patient services, hospital medical	*Interestingly, this is the same study as above, but they report different n for participants in each group (e.g. born in UK, or rates of depression).* *Also didn't disaggregate by gender.*

				services, or informal care than British. Irish more likely to have GP visit than British, Africa/Caribbean less likely to use informal care, more likely to use day services than British.	
McColl and Johnson, 2006[211]					
Cross-sectional study.	Current or former asylum seekers on caseloads of three inner London Community Mental Health Teams between January and December 2003, aged 18-65.	104 patients (42 women, 60 men)	Clinicians and case notes; Camberwell Assessment of Need Short Appraisal Schedule (CANSAS), Health of the Nation Outcome Scales (HoNOS)	41% PTSD, 36% depression without psychotic symptoms (14% depression with psychotic symptoms); 32% had diagnosis of depression *and* PTSD); 52% had one or more diagnoses of psychosis, 15% in addition had recorded psychotic symptoms but no diagnosis. 30% met criteria for diagnostic uncertainty (3 or more primary diagnoses in their first year of CMHT or consultant psychiatrist stated diagnosis uncertain). 54% had unmet need for psychological distress.	*Did not disaggregate by gender*
McCrone et al, 2005[212]					
Cross-sectional	Somali refugees from	143 Somali	Camberwell	2% of participants from	*See Bhui et al,*

study.	Tower Hamlets and Lambeth, London (random sample of people with Somali names registered with local GPs, refugees attending 'non-conventional sites' (e.g. cafes, community centres, mosques, further education colleges, refugee hostels).	refugees (71 men, 72 women).	Assessment of Need (CAN); Client Service Receipt Inventory (CSRI).	non-conventional sites and 5% of participants from conventional sites had unmet need relating to psychological distress.	*2006 – same study sample.* *Did not disaggregate by gender.*
Mcgovern and Cope, 1987[624]					
Cross-sectional study.	Patients aged 16-65 selected from case notes of male patients. Patients residing outside catchment area excluded as were admissions to the Alcohol and Addiction Unit.	67 patients admitted under part V of Mental Health Act (January 1975 – December 1982), 217 under part IV of the Act (January 1979 – December 1982), 574 general admissions.	Case notes.	Diagnosis of affective disorder: White (British): 29.5% West Indian Migrant: 15% British West Indian: 8% Asian Migrant: 29%	*All male sample.*
McGovern and Cope, 1987[219]					
Cross-sectional study.	Males aged 16-64 and females aged 16-59 recorded on statutory Form HMRI at Birmingham Psychiatric Hospital as first admissions included; Individuals previously admitted to psychiatric	724 participants (323 males, 401 females); 611 White (British), 72 Afro Caribbean migrants, 41 British-born Afro Caribbean's.	Case notes.	Rate of affective disorder per 100,000: White male: 24.8 First-generation Afro Caribbean male: 11.3 White Female: 48.3 First-generation Afro Caribbean female: 26.5	

	hospitals or residing outside of catchment area excluded. 'First generation' Afro Caribbean: migrants over 30 years of age 'Second Generation' Afro Caribbean: migrants aged 16-29 years or British-born Afro Caribbean's aged 16-29				
Mezey, 1960[213]					
Cross-sectional study.	Data on Hungarian refugees referred for psychiatric disorders from February 1957 – January 1959; patients referred by hospitals, GPS, Refugee Welfare organisations, official channels, or self-referral	Data for 82 participants; 65 interviewed patients (didn't state how many men and women).	Case records; interview and examination.	23 of the cases had diagnoses for effective disorders, including depressive states and hypomania. More men in each diagnostic group for all age groups except 55-64 where all individuals with affective disorders were female.	*Could have disaggregated more of results by gender.*
Myers and Neal, 1978[190]					
Case-control study.	Individuals who committed suicide in Shropshire 1965-1973 who had seen a psychiatrist; sex-matched psychiatric controls.	100 cases (49 men, 51 women); 7 of suicides Eastern European immigrant community.	Hospital records.	Rate of suicide among Eastern European sample higher than for rest of Shropshire population ($X^{2=63,}$ p<0.001).	*In immigrant analysis, did not disaggregate by gender.*
Papadopoulos et al, 2004[100]					
Qualitative study (in-depth	Ethiopians recruited through contacts with	106 Ethiopians (52% female, 48%	In-depth interviews (thematic analysis)	Becoming a foreigner and asylum seeker and	

interviews, semi-structured questionnaires).	Ethiopian community and through advertisements on Ethiopian radio station. Aged 12 or over.	male); 98 lay participants (5 with history of diagnosed mental illness) and 8 expert participants (Ethiopians providing professional services for Ethiopian refugees).	and semi-structure questionnaires.	associated stigma, difficulty adapting to British culture cause of stress, depression, and poor health. Problems in experiences with UK immigration department (e.g. length of time of interviews). Barriers to work, poor living conditions, financial difficulties, isolation. Happiness was reported to be most important indication of health. Distinction made between emotional problems ('normal') and 'madness' (often seen to be due to possession. 45% of participants said they felt sad or unhappy for long periods of time. 75% of these said they would like to talk to someone trained in working with refugees about their feelings.	
Robjant and Senior, 2009[197]					
Cross-sectional study.	Aged 18 or over.	146 participants (98 male, 48 female). 67 detained asylum seekers, 30	Hospital Anxiety and Depression Scale (HADS); Impact of Event Scale-Revised (IES-R); part I of Post-	Clinical cases depression: Detained: 76%, former prisoners: 67%, Community: 26%. Detained asylum seekers	*Didn't disaggregate by gender.*

		detainees who had previously been imprisoned in UK for criminal offences, 49 asylum seekers living in community.	traumatic Diagnostic Scale (PDS).	more depressed than community group (t(106)=5.04, p<0.001). Clinical cases anxiety: Detained: 72%, former prisoners: 73%, Community: 50%. Detained asylum seekers more anxious than asylum seekers in community (mean difference 2.96 [SE=1.09], p=0.02). Detained asylum seekers also had higher IES-R scores than community sample (mean difference =13.67 [SE=5.64], p<0.05).	
Ryan et al, 2006[191]					
Case-control study.	Aged 18 years or older recruited from general practices in North London using first/last names that were Irish. Participants who scored 11 or above on Hospital Anxiety and Depression Scale or reported episode of depression in last 12 months classified as cases. Individuals who migrated prior to age of 15 excluded.	360 Irish born immigrants (180 with depression, 180 without depression).	Hospital Anxiety and Depression Scale (HADS); Beck Depression Inventory (BDI).	Poorly planned migration associated with depression (OR: 1.20 [95% CI: 1.06 – 1.35]). Participants with depression more likely to report low level of acculturation (OR: 1.73 [95%CI: 1.11 – 2.69]). Men had significantly higher scores than women on HADS and	

				BDI, but no more likely to be receiving treatment.	
Sabes-Figuera et al, 2012[239]					
Cross-sectional study.	Participants from former Yugoslavia, aged 18-65, experienced at least on war-related event with last event at or after age 16, no mental impairment due to brain injury or organic cause. Participants from five countries in Balkan region and three West European countries with refugees from the area. In UK participants recruited through community organisations and snowballing.	3313 participants total; 854 war refugees across former Yugoslavia in Germany, Italy, and the UK (302 in UK, including 168 women and 134 men; 67.9% from Bosnia and Herzegovina)	Mini International Neuropsychiatric Interview (MINI); Life Stressor Checklist-Revised; Client Service Receipt Inventory (CSRI).	57.4% any mood disorder UK sample; 28.8% PTSD; 13.6% other anxiety disorder. Service use for UK participants: Any health care service: 88.7%, 75.2% community health care, 10.3% psychiatric services, 52.3% other specialist health services, 67.2% medication.	*See Bogic et al, 2012 – same study* *Didn't disaggregate by gender.*
Silveira and Allebeck, 2001[220]					
Qualitative study (ethnographic study using semi-structured interviews).	Male Somali migrants aged 60 or older from Tower Hamlets, London representing a range of LSI/SAD spectrum (assessed using Life Satisfaction Index and Symptoms of Anxiety and Depression scale in previous interviews – see Silveira and Ebrahim, 1998 below).	28 male Somali migrants.	Semi-structured interviews (thematic analysis).	Poverty and dependency, unmet housing needs/dissatisfaction with economic status; family support contributed to life satisfaction; dream of return home; access to health and social services related to life satisfaction. Depression defined and	*See Silveira and Ebrahim, 1998 below.* *Only male migrants.*

				equated with worrying, sleeplessness, loneliness, low morale, experience of unusual negative things; religious practices and attitudes important for coping.	
Silveira and Ebrahim, 1998[226]					
Cross-sectional survey.	Aged 60 or older recruited through lunch clubs, snowballing, register of general practice.	274 participants, 172 men and 102 women (72 Somalis, 75 Bengalis, 127 whites).	Self-rating Scale of Anxiety and Depression (SAD); Life Satisfaction Index (LSI).	77% Bengalis in depressed range, compared to 25% among Somalis and Whites. Increase in social problems had negative effect on SAD scores among Somalis and Bengalis. Membership of ethnic minority group non-significantly associated with SAD scores after adjusting for age, income, health, and social factors; being in immigrant group associated with lower LSI score after adjusting for the above variables (OR: 0.7 [95% CI: 0.4 -1).	*Did not disaggregate by gender.*
Suhail and Cochrane, 1997[188]					
Cohort Study.	Asian, Asian-British, and White women aged 18-	25 Asian women, 25 Asian-British	Hospital Anxiety and Depression Scale	Significant effect of seasons for Asian group	

	40 years from general population. Asian women had either Pakistani, Indian, or Bangladeshi origin (matched for age and socio-economic status). For Asian women, total length of residence in England not more than 10 years. Participants interviewed every month for 1 year.	women, 25 white women.	(HADS), Behavioural Change Inventory (BCI), Monthly Stress Inventory (MSI), Ladder Scale of General Well-being (LSW); Seasonal Pattern and Assessment Questionnaire (SPAQ).	(F=9.55, p<0.001); greater than for Asian British (F=2.76, p≤0.05), and white (F=2.79, p≤0.05)	
Tabassum et al, 2000[625]					
Qualitative study (semi-structured interviews).	First generation immigrant women (born and spent childhood in Pakistan, aged between 22 and 25 years on entry to Britain). Second generation women (born and brought up in UK). Male heads of household (all born in Pakistan). Recruited from general practitioners, social workers, community health care worker, personal contacts in Darnall, Sheffield.	29 first generation women (1 born in UK), 23 second generation (7 were born in Pakistan but came to UK before age of five). 22 males.	Semi-structured interviews (content analysis).	Symptoms perceived as indicating mental illness: depression most significant factor: 31% males, 41% 1st generation females, 34% 2nd generation females. Opinions about likely causes of mental illness similar across gender and generation. Stress at home was most frequently selected factor, then unhappiness. Language was biggest barrier for not attending hospital, followed by social stigma. Males suggested reluctance to admit females as	

				perceived their (men's) domestic burdens would increase.	
Turner et al, 2003[215]					
Cross-sectional study.	Kosovan refugees from reception centres in north of England.	842 adult refugees (47.1% men, 52.9% women)	War Trauma Questionnaire; Beck Depression Inventory (BDI); Beck Anxiety Inventory (BAI); 28-item General Health Questionnaire (GHQ); Post-traumatic Diagnostic Scale (PDS).	59.9% above threshold for GHQ. Mean score for BDI: 18.89 (s.d. 14.18); 61.4% had possible depression. BAI mean score: 14.09 (s.d. 14.50). 56.9% have score indicating possible anxiety. PDS: 64% met criteria for probable diagnosis of PTSD. Exposure to violence significantly positively correlated with GHQ, BDI, BAI, and PDS.	*Low response rate for PDS.* *Did not give any statistics stratifying by gender.*
Watson and Evans, 1986[222]					
Cross-sectional study.	Mothers randomly selected from Birth Notifications from District Community Office. Interviewed at 8 weeks, 8 months, and 14 months after birth of child.	101 mothers - 93 mothers did all 3 interviews: 49 indigenous, 28 Bengali immigrants, and 24 'other' English speaking immigrants.	General Health Questionnaire; asked if depressed at moment; interviewer rating of whether or not mothers showed any distress.	Interview 1: GHQ: 17% Bengali depressed; 20% Other immigrants depressed; 27% indigenous depressed. Interview 2: GHQ: 12% Bengali depressed; 18% Other immigrants depressed; 15% indigenous depressed.	

				Interview 3: GHQ: 27% Bengali depressed; 14% Other immigrants depressed; 17% indigenous depressed. Fair amount of agreement between measures.	
Wilson, 1978[223]					
Qualitative study (in-depth interviews and ethnographic research).	Women from Punjab, Bangladesh, or Gujarat; community workers; health services staff.	Immigrant women, their families, community workers, service providers.	In-depth interviews and ethnographic research.	Dependants (to join husbands); experiences of racism (from health service, social workers, and neighbours); isolation; depression.	*This paper does is a descriptive account of the authors ethnographic research and interviews; it does not describe the methodology, number of participants etc, but may still provide an important 'insider perspective'.*
Yoshida et al, 1997[214]					
Cross-sectional study.	Women who became pregnant in England (monitored from 36 weeks gestation to 3 months postpartum). Recruited from antenatal classes for pregnant	98 Japanese women.	Edinburgh Postnatal Depression Scale (EPDS); Schedule for Affective Disorders and Schizophrenia (SADS); Life Event Scale.	12% mothers categorised as having new onsets of depression postpartum; depression associated with having a stressful life event or obstetric difficulty without grandmother's support.	

	Japanese women and their husbands, and from an advertisement in a maternity guidebook for pregnant Japanese women in the UK.			Japanese women may be less likely to express depressive symptoms by self-report.	

Appendix 3: SELCoH Study survey questionnaire

Questions in the SELCoH Study questionnaire relevant to this thesis are provided.

Socio-demographic section

What is your date of birth? _____

What was your age on your last birthday? _____

1.3. Are you

□□single, that is, never married
□□single and living with your partner
□□married and living with your husband/wife
□□married and separated from your husband/wife
□□divorced
□□or widowed?

1.5. Do you have children?

□□Yes □□How many? _____
□□No

1.8. To which of the following groups do you consider you belong?

□□White
□□Black - Caribbean
□□Black - African
□□Black - Other Black Groups
□□Indian
□□Pakistani
□□Bangladeshi
□□Chinese
□□None of these

1.9. Up to the age of 16 did you spend any time in any kind of institution such as a children's home, borstal, or young offenders unit? (EXCLUDE PRIVATE EDUCATION BOARDING SCHOOL)

□□Yes
□□No

1.10. (May I just check) were you ever taken into Local Authority Care (that is into a children's home or foster care) as a child up to the age of 16?

□□Yes
□□No
□□DNA, Foreign national

1.11. Did you drop out of school before the age of 15 before you received your qualification?

□□Yes
□□No

1.12. I am going to mention several qualifications. Could you tell me whether you have passed any of them.

□□Degree level qualification or above
□□'A'Level or equivalent (HNDs, NVQ level 3, Highers)
□□GSCE level or equivalent (O'levels, NVQ level 1-2)
□□Below GCSE level
□□Other qualifications (specify)_____
□□No qualifications

Income

1.15. Could you please look at the screen and click on which group represents your household's weekly gross income from all sources? (By gross income, I mean income from all sources before deductions for income tax and National Insurance) *(Including all social security benefits except housing benefit and council tax benefit, including private/occupational pension)*

□□£0 - £105 (£0 - £5,475 p.a.) (£0 - £420 p.m.)
□□£106 - £232 ((£5476 - £12,097 p.a.) (£421 - £928 p.m.)

□□£233 - £398 (£12,098 - £20,753 p.a.) (£929 - £1,592 p.m.)
□□£399 - £604 (£20,754 - £31,494 p.a.) (£1,593 - £2,416 p.m.)
□□£605 or more (£31,495 or more p.a.) (£2,417 or more p.m.)

Employment section

1.25. Which of these best describes your current work status?
□□Full time work
□□Part time work
□□Casual work
□□Student
□□Unemployed
□□Temporary sick
□□Permanent sick/disabled
□□Retired
□□Looking after the home with children <16
□□Looking after the home with children ≥16

CIS-R for mental disorders symptoms section

4. Section A – Somatic Symptoms

4.1. Have you had any sort of ache or pain in the past month?
□□Yes
□□No
4.2. During the past month have you been troubled by any sort of discomfort, for example, headache or indigestion?
□□Yes
□□No
4.3. (If yes) Was this ache or pain/discomfort brought on or made worse because you were feeling low, anxious or stressed? (IF INFORMANT HAS MORE THAN ONE PAIN/DISCOMFORT, REFER TO ANY OF THEM)
□□Yes
□□No
4.4. In the past seven days, including last (DAY), on how many days have you noticed the ache or pain/discomfort?
□□4 days or more
□□1 to 3 days
□□None
4.5. In total, did the ache or pain/discomfort last for more than 3 hours on any day in the past week/on that day?
□□Yes
□□No
4.6. In the past week, has the ache or pain/discomfort been...
□□very unpleasant
□□a little unpleasant
□□or not unpleasant?
4.7. Has the ache or pain/discomfort bothered you when you were doing something interesting in the past week?
□□Yes
□□No/has not done anything interesting
4.8. How long have you been feeling this ache or pain/discomfort as you have just described?
□□less than 2 weeks
□□more than 2 weeks but less than 6 months
□□more than 6 months but less than 1 year
□□more than 1 year but less than 2 years
□□2 years or more

5. Section B – Fatigue

5.1. Have you noticed that you've been getting tired in the past month?

□□Yes
□□No
5.2. During the past month, have you felt you've been lacking in energy?
□□Yes
□□No
5.3. (If yes) Do you know why you have been feeling tired/lacking in energy?
□□Yes
□□No
5.4. What is the main reason? Can you choose from this card? SHOW CARD 11
□□Problems with sleep
□□Medication
□□Physical illness
□□Working too hard
□□Stress, worry or other psychological reason
□□Physical exercise
□□Other
5.5. In the past seven days, including last (DAY) on how many days have you felt tired/lacking in energy?
□□4 days or more
□□1 to 3 days
□□None
5.6. Have you felt tired/lacking in energy for more than 3 hours in total on any day in the past week? (EXCLUDE TIME SPENT SLEEPING)
□□Yes
□□No
5.7. Have you felt so tired/lacking in energy that you've had to push yourself to get things done during the past week?
□□Yes, on at least one occasion
□□No
5.8. Have you felt tired/lacking in energy when doing things that you enjoy during the past week?
□□Yes, at least once
□□No
□□Does not enjoy anything
5.9. Have you in the past week felt tired/lacking in energy when doing things that you used to enjoy?
□□Yes
□□No
5.10. How long have you been feeling tired/lacking in energy in the way you have just described? SHOW CARD 10
□□less than 2 weeks
□□More than 2 weeks but less than 6 months
□□More than 6 months but less than 1 year
□□More than 1 year but less than 2 years
□□2 years or more

6. Section C – Concentration and Forgetfulness

6.1. In the past month, have you had any problems in concentrating on what you are doing?
□□Yes, problems concentrating
□□No
6.2. Have you noticed any problems with forgetting things in the past month?
□□Yes
□□No
6.3. (If yes) Since last (DAY), on how many days have you noticed problems with your concentration/memory?
□□4 days or more

□□1 to 3 days
□□None
6.4. In the past week could you concentrate on a TV programme, read a newspaper article or talk to someone without your mind wandering?
□□Yes
□□No/not always
6.5. In the past week, have these problems with your concentration actually stopped you from getting on with things you used to do or would like to do?
□□Yes
□□No
6.6. (Earlier you said you have been forgetting things.) Have you forgotten anything important in the past seven days?
□□Yes
□□No
6.7. How long have you been having the problems with your concentration /memory as you have described? SHOW CARD 10
□□less than 2 weeks
□□More than 2 weeks but less than 6 months
□□More than 6 months but less than 1 year
□□More than 1 year but less than 2 years
□□More than 2 years or more

7. Section D – Sleep Problems

7.1. In the past month, have you been having problems with trying to get to sleep or with getting back to sleep if you woke up or were woken up?
□□Yes
□□No
7.2. Has sleeping more than you usually do been a problem for you in the past month?
□□Yes
□□No
7.3. On how many of the past seven nights did you have problems with your sleep?
□□4 nights or more
□□1 to 3 nights
□□None
7.4. Do you know why you are having problems with your sleep?
□□Yes
□□No
7.5. Can you look at this card and tell me the main reason for these problems? SHOW CARD 12
□□Noise
□□Shift work/too busy to sleep
□□Illness/discomfort
□□Worry/thinking
□□Needing to go to the toilet
□□Having to do something (eg look after baby)
□□Tired
□□Medication
□□Other
7.6. Thinking about the night you had the least sleep in the past week, how long did you spend trying to get to sleep? (If you woke up or were woken up I want you to allow a quarter of an hour to get back to sleep). Only include time spent trying to get to sleep.
□□Less than 1/4 hr
□□At least 1/4 hr but less than 1 hr
□□At least 1 hr but less than 3 hrs
□□3 hrs or more
7.7. In the past week, on how many nights did you spend 3 or more hours trying to get to sleep?
□□4 nights or more

□□1 to 3 nights
□□None
7.8. Do you wake more than two hours earlier than you need to and then find you can't get back to sleep?
□□Yes
□□No
7.9. How long have you had these problems with your sleep as you have described? SHOW CARD 10
□□Less than 2 weeks
□□More than 2 weeks but less than 6 months
□□More than 6 months but less than 1 year
□□More than 1 year but less than 2 years
□□2 years or more
7.10. Thinking about the night you slept the longest in the past week, how much longer did you sleep compared with how long you normally sleep for?
□□Less than 1/4 hr
□□At least 1/4 hr but less than 1 hr
□□At least 1 hr but less than 3 hrs
□□3 hrs or more
7.11. In the past week, on how many nights did you sleep for more than 3 hours longer than you usually do?
□□4 nights or more
□□1 to 3 nights
□□None
7.12. How long have you had these problems with your sleep as you have described? SHOW CARD 10
□□Less than 2 weeks
□□More than 2 weeks but less than 6 months
□□More than 6 months but less than 1 year
□□More than 1 year but less than 2 years
□□2 years or more

8. Section E – Irritability

Many people become irritable or short tempered at times, though they may not show it.
8.1. Have you felt irritable or short tempered with those around you in the past month?
□□Yes/no more than usual
□□No
8.2. During the past month did you get short tempered or angry over things which now seem trivial when you look back on them?
□□Yes
□□No
8.3. Since last (DAY), on how many days have you felt irritable or short tempered/angry?
□□4 days or more
□□1 to 3 days
□□None
8.4. What sort of things made you irritable or short tempered/angry in the past week?
8.5. In total, have you felt irritable or short tempered/angry for more than one hour (on any day in the past week)?
□□Yes
□□No
8.6. During the past week, have you felt so irritable or short tempered/angry that you have wanted to shout at someone, even if you haven't actually shouted?
□□Yes
□□No
8.7. In the past seven days, have you had arguments, rows or quarrels or lost your temper with anyone?

□□Yes
□□No
8.8. Did this happen once or more than once (in the past week)?
□□Once
□□More than once
8.9. Do you think this was justified?
□□Yes, justified
□□No, not justified
8.10. Do you think this was justified on every occasion?
□□Yes
□□No, at least one was unjustified
8.11. How long have you been feeling irritable or short tempered/angry as you have described? SHOW CARD 10
□□Less than 2 weeks
□□More than 2 weeks but less than 6 months
□□More than 6 months but less than 1 year
□□More than 1 year but less than 2 years
□□2 years or more

9. Section F – Worry about Physical Health

Many people get concerned about their physical health.
9.1. In the past month, have you been at all worried about your physical health? (INCLUDE WOMEN WHO ARE WORRIED ABOUT THEIR PREGNANCY)
□□Yes, worried
□□No/concerned
INTERVIEWER: HAS INFORMANT MENTIONED A PHYSICAL HEALTH PROBLEM? YOU ENTERED THE FOLLOWING ILLNESS/ES: (NAMES OF ILLNESSES MENTIONED)
□□Yes, has mentioned a physical health problem
□□No physical health problem
9.2. During the past month, did you find yourself worrying that you might have a serious physical illness?
□□Yes
□□No
9.3. Thinking about the past seven days, including last (DAY), on how many days have you found yourself worrying/feeling concerned about your physical health?
□□4 days or more
□□1 to 3 days
□□None
9.4. In your opinion, have you been worrying too much in view of your actual health?
□□Yes
□□No
9.5. In the past week, has this worrying been...
□□very unpleasant
□□a little unpleasant
□□or not unpleasant?
9.6. In the past week, have you been able to take your mind off your health worries at least once, by doing something else?
□□Yes
□□No, could not be distracted once
9.7. How long have you been worrying about your physical health in the way you described? SHOW CARD 10
□□Less than 2 weeks
□□More than 2 weeks but less than 6 months
□□More than 6 months but less than 1 year
□□More than 1 year but less than 2 years
□□More than 2 years or more

10. Section G – Depression

Almost everyone becomes sad, miserable or depressed at times.

10.1. Have you had a spell of feeling sad, miserable or depressed in the past month?

□□Yes

□□No

10.2. During the past month, have you been able to enjoy or take an interest in things as much as you usually do?

□□Yes

□□No/no enjoyment or interest

10.3. In the past week have you had a spell of feeling sad, miserable or depressed?

□□Yes

□□No

10.4. In the past week have you been able to enjoy or take an interest in things as much as usual?

□□Yes

□□No/no enjoyment or interest

10.5. Since last (DAY) on how many days have you felt sad miserable or depressed / unable to enjoy or take an interest in things?

□□4 days or more

□□1 to 3 days

□□None

10.6. Have you felt sad miserable or depressed / unable to enjoy or take an interest in things for more than 3 hours in total (on any day in the past week)?

□□Yes

□□No

10.7. In the past week when you felt sad, miserable or depressed/unable to enjoy or take an interest in things, did you ever become happier when something nice happened, or when you were in company?

□□Yes, at least once

□□No

10.8. How long have you been feeling sad, miserable or depressed/unable to enjoy or take an interest in things as you have described? SHOW CARD 10

□□Less than 2 weeks

□□More than 2 weeks but less than 6 months

□□More than 6 months but less than 1 year

□□More than 1 year but less than 2 years

□□More than 2 years or more

11. Section H – Depressive Ideas

I would now like to ask you about when you have been feeling miserable, depressed r unable to take

an interest in things.

11.1. In the past week, was this worse in the morning or in the evening, or did this make no difference?

□□in the morning

□□in the evening

□□no difference/other

Many people find that feeling miserable, depressed or unable to take an interest can affect their interest in sex.

11.2. Over the past month, do you think your interest in sex has

□□increased

□□decreased

□□has it stayed the same?

□□Not applicable

11.3. When you have felt miserable, depressed or unable to take an interest in things in the past seven days ... have you been so restless that you couldn't sit still?

□□Yes

□□No
11.4. ..... have you been doing things more slowly, for example, walking more slowly?
□□Yes
□□No
11.5. ....have you been less talkative than normal?
□□Yes
□□No
11.6. Now, thinking about the past seven days have you on at least one occasion felt guilty or blamed yourself when things went wrong when it hasn't been your fault?
□□Yes, at least once
□□No
11.7. During the past week, have you been feeling you are not as good as other people?
□□Yes
□□No
11.8. Have you felt hopeless at all during the past seven days, for instance about your future?
□□Yes
□□No
Thank you for answering those questions on how you have been feeling

12. Section I – Worry

The next few questions are about worrying.
12.1. In the past month, did you find yourself worrying more than you needed to about things?
□□Yes, worrying
□□No/concerned
12.2. Have you had any worries at all in the past month?
□□Yes
□□No
For the next few questions, I want you to think about worries you have had other than those about your physical health.
12.3. On how many of the past seven days have you been worrying about things (other than your physical health)?
□□4 days or more
□□1 to 3 days
□□None
12.4. In your opinion, have you been worrying too much in view of your circumstances? (REFER TO WORRIES OTHER THAN THOSE ABOUT PHYSICAL HEALTH)
□□Yes
□□No
12.5. In the past week, has this worrying been: (REFER TO WORRIES OTHER THAN THOSE ABOUT
PHYSICAL HEALTH)
□□very unpleasant
□□a little unpleasant
□□or not unpleasant?
12.6. Have you worried for more than 3 hours in total on any one of the past seven days? (REFER TO WORRIES OTHER THAN THOSE ABOUT PHYSICAL HEALTH)
□□Yes
□□No
12.7. How long have you been worrying about things in the way you have described? SHOW CARD
10□□Less than 2 weeks
□□More than 2 weeks but less than 6 months
□□More than 6 months but less than 1 year
□□More than 1 year but less than 2 years
□□More than 2 years or more
Reason
12.8. Can you look at this card and tell me what sorts of things have been making you

worried/depressed/worried and depressed? SHOW CARD 14, CODE ALL THAT APPLY
□□Members of the family
□□Relationship with spouse/partner
□□Relationships with friends
□□Housing
□□Money/bills
□□Own physical health (inc. pregnancy)
□□Own mental health
□□Work or lack of work
□□Legal difficulties
□□Political issues/the news
□□Other
□□Don't know/no main thing
Main Reason
12.9. What was the main thing you have been worried/depressed/worried and depressed about? CARD 14
□□Members of the family
□□Relationship with spouse/partner
□□Relationships with friends
□□Housing
□□Money/bills
□□Own physical health (inc. pregnancy)
□□Own mental health
□□Work or lack of work
□□Legal difficulties
□□Political issues/the news
□□Other
□□Don't know/no main thing

13. Section J – Anxiety

13.1. Have you been feeling anxious or nervous in the past month?
□□Yes, anxious or nervous
□□No
13.2. (If no) In the past month, did you ever find your muscles felt tense or that you couldn't relax?
□□Yes
□□No
Some people have phobias; they get nervous or uncomfortable about specific things or situations when there is no real danger. For instance they may get extremely anxious when in confined spaces,
or they may have a fear of heights. Others become nervous at the sight of things like blood or spiders.
13.3. In the past month have you felt anxious, nervous or tense about any specific things when there was no real danger?
□□Yes
□□No
13.4. In the past month, when you felt anxious/nervous/tense, was this always brought on by the phobia about some specific situation or thing or did you sometimes feel generally anxious/nervous/tense?
□□Always brought on by phobia
□□Sometimes generally anxious
The next questions are concerned with general anxiety/nervousness/tension only.
I will ask you about the anxiety which is brought on by the phobia about specific things or situations later.
13.5. On how many of the past seven days have you felt generally anxious/nervous/tense?
□□4 days or more

□□1 to 3 days
□□None
13.6. On how many of the past seven days have you felt generally anxious/nervous/tense?
□□4 days or more
□□1 to 3 days
□□None
13.7. In the past week, has your anxiety/nervousness/tension been:
□□very unpleasant
□□a little unpleasant
□□or not unpleasant?
13.8. In the past week, when you've been anxious/nervous/tense, have you had any of the symptoms shown on this card? SHOW CARD 15
□□Yes
□□No
13.9. (If yes) Which of these symptoms did you have when you felt anxious/nervous/tense? CODE ALL THAT APPLY
□□Heart racing or pounding
□□Hands sweating or shaking
□□Feeling dizzy
□□Difficulty getting your breath
□□Butterflies in stomach
□□Dry mouth
□□Nausea or feeling as though you wanted to vomit
13.10. Have you felt anxious/nervous/tense for more than 3 hours in total on any one of the past seven days?
□□Yes
□□No
13.11. How long have you had these feelings of general anxiety/nervousness/tension as you described? SHOW CARD 10
□□Less than 2 weeks
□□More than 2 weeks but less than 6 months
□□More than 6 months but less than 1 year
□□More than 1 year but less than 2 years
□□More than 2 years or more

14. Section K – Phobias

Sometimes people avoid a specific situation or thing because they have a phobia about it.
14.1. In the past month, have you avoided any situation or thing because it would have made you feel nervous or anxious, even though there was no real danger?
□□Yes
□□No
14.2. Can you look at this card and tell me which of the situations or things listed made you the most anxious/nervous/tense in the past month? SHOW CARD 16, CODE ALL THAT APPLY
□□Crowds or public places
□□Enclosed spaces
□□Social situations
□□Sight of blood or injury
□□Specific single cause
□□Other (SPECIFY)
14.3. Can you look at this card and tell me which of the situations or things listed did you avoid the most in the past month? SHOW CARD 16, CODE ALL THAT APPLY
□□Crowds or public places
□□Enclosed spaces
□□Social situations
□□Sight of blood or injury
□□Specific single cause

□□Other (SPECIFY)
14.4. In the past seven days, how many times have you felt nervous or anxious about (SITUATION(S)/THING(S))?
□□4 times or more
□□1 to 3 times
□□None
14.5. In the past week, on those occasions when you felt anxious/nervous/tense did you have any of the symptoms on this card? SHOW CARD 15
□□Yes
□□No
14.6. Which of these symptoms did you have when you felt anxious/nervous/tense? SHOW CARD 15
□□Heart racing or pounding
□□Hands sweating or shaking
□□Feeling dizzy
□□Difficulty getting your breath
□□Butterflies in stomach
□□Dry mouth
□□Nausea or feeling as though you wanted to vomit
14.7. In the past week, have you avoided any situation or thing because it would have made you feel anxious/nervous/tense even though there was no real danger?
□□Yes
□□No
14.8. How many times have your avoided such situations or things in the past seven days?
□□4 days or more
□□1 to 3 days
□□None
14.9. How long have you been having these feelings about these situations/things as you have just described? SHOW CARD 10
□□Less than 2 weeks
□□More than 2 weeks but less than 6 months
□□More than 6 months but less than 1 year
□□More than 1 year but less than 2 years
□□More than 2 years or more

15. Section L – Panic

15.1. Thinking about the past month, did your anxiety or tension ever get so bad that you got in a panic, for instance make you feel that you might collapse or lose control unless you did something about it?
□□Yes
□□No
15.2. How often has this happened in the past week?
□□Once
□□More than once
□□Not at all
15.3. In the past week, have these feelings of panic been:
□□a little uncomfortable or unpleasant
□□or have they been very unpleasant or unbearable?
15.4. Did this panic/the worst of these panics last for longer than 10 minutes?
□□Yes
□□No
15.5. Are you relatively free of anxiety between these panics?
□□Yes
□□No
15.6. Is this panic always brought on by (LIST OF PHOBIAS MENTIONED)?
□□Yes

□□No
15.7. How long have you been having these feelings of panic as you have described? SHOW CARD
10□□Less than 2 weeks
□□More than 2 weeks but less than 6 months
□□More than 6 months but less than 1 year
□□More than 1 year but less than 2 years
□□More than 2 years or more

16. Section M – Compulsions

16.1. In the past month, did you find that you kept on doing things over and over again when you knew you had already done them. For example, making your bed or washing your hands over and over again?
□□Yes
□□No
16.2. (If yes) On how many days in the past week did you find yourself doing things over again that you had already done?
□□4 days or more
□□1 to 3 days
□□None
16.3. Since last (DAY) what sorts of things have you done over and over again? _____
16.4. During the past week, have you tried to stop yourself repeating (BEHAVIOUR)/doing any of these things over again?
□□Yes
□□No
16.5. (If yes) Has repeating (BEHAVIOUR)/doing any of these things over again made you upset or annoyed with yourself in the past week?
□□Yes, upset or annoyed
□□No, not at all
16.6. (If yes) INTERVIEWER: IS MORE THAN ONE THING REPEATED
□□Yes
□□No
16.7. (If yes) Thinking about the past week, which of the things you mentioned did you repeat the most times? _____
16.8. (If yes) Since last (DAY), how many times did you repeat (DESCRIPTION OF MAIN COMPULSION) when you had already done it?
□□3 Times or more
□□Twice
□□Once
16.9. (If yes) How long have you been repeating (BEHAVIOUR)/any of the things you mentioned in the way which you have described? SHOW CARD 10
□□less than 2 weeks
□□2 weeks but less than 6 months
□□6 months but less than 1 year
□□1 year but less than 2 years
□□2 years or more

17. Section N – Obsessions

17.1. In the past month did you have any thoughts or ideas over and over again that you found unpleasant and would prefer not to think about, that still kept on coming into your mind? For example, constantly thinking about death
□□Yes
□□No
17.2. (If yes) Can I check, is this the same thought or idea over and over again or are you worrying about a problem or something in general?
□□Same thought
□□Worrying in general

17.3. (If yes) What are these unpleasant thoughts or ideas that keep coming into your mind?
_____
17.4. (If yes) Since last (DAY), on how many days have you had these unpleasant thoughts?
□□4 days or more
□□1 to 3 days
□□None
17.5. (If yes) During the past week, have you tried to stop yourself thinking any of these thoughts?
□□Yes
□□No
17.6. (If yes) Have you become upset or annoyed with yourself when you have had these thoughts in the past week?
□□Yes, upset or annoyed
□□No Not at all
17.7. (If yes) In the past week, was the longest episode of having such thoughts...
□□a quarter of an hour or longer
□□15min or was it less than this?
17.8. (If yes) How long have you been having these thoughts in the way which you have just described? SHOW CARD 10
□□less than 2 weeks
□□2 weeks but less than 6 months
□□6 months but less than 1 year
□□1 year but less than 2 years
□□2 years or more

18. Section O – Overall Effects

Now I would like to ask you how all of these things that you have told me about have affected you overall.
18.1. In the past week, has the way you have been feeling ever actually stopped you from getting on with things you used to do or would like to do?
□□Yes
□□No
18.2. (If yes) In the past week, has the way you have been feeling stopped you doing things once or more than once?
□□Once
□□More than once
18.3. (If no)Has the way you have been feeling made things more difficult even though you have got everything done?
□□Yes
□□No

24.Social support section

The next set of question is about your Social network and support
Social Network
24.1. In a typical week, how many of the following people do you come in contact with? By contact, we mean talking either face to face or by phone. Give us your best guess.
□□Brother/sister
□□In-laws
□□Other relatives
□□Close friends
□□Neighbours
□□Co-workers
□□Boss/supervisor
□□Other acquaintances
□□Helping professionals
□□Member of same group or club
Now I would like to present you with some hypothetical situations. I would like to know if you

could get help or assistance in the following situations if you needed it. Remember these are hypothetical situations. Then I would like to ask you if these situations ACTUALLY happened to you.

Situation Yes No
Actually
happened

24.2. Someone to lend you money to pay bills or help you get along □ □ □

24.3. Someone to help you deal with an emergency (minor or health emergency) □ □ □

24.4. Someone to talk to about something that was bothering you or when you felt lonely and wanted some company
□ □ □

24.5. Someone to make you feel good, loved or cared for □ □ □

25.Stressful life events section

When you were growing up (before age 16):

25.1. Did you ever have a major illness or accident that required you to spend a week or more in hospital?
□□Yes
□□No

25.2. Did your parents get a divorce?
□□Yes
□□No

25.3. Did either of your parents die?
□□Yes
□□No

25.4. Were you ever separated from either of your parents or not living in the household with both parents?
□□Yes
□□No

25.5. Did anyone ever hit you so hard that it left bruises or marks?
□□Yes
□□No

25.6. Did anyone who was responsible for your care such as a parent, caregiver, or babysitter—or someone else who was at least 5 years older than you—ever sexually abused you? *(If explanation needed: touch your sexual parts - by that I mean, your vagina, penis, anus, or breasts - make you touch their sexual parts, or make you watch sexual things)*
□□Yes
□□No

The next questions refer to your lifetime:

25.7. Have you ever lived with someone as a couple and that relationship ended in separation or divorce?
□□Yes□□Did this happen within the last 12 months?
□□Yes
□□No
□□No

25.8. Has a spouse/partner, child, or other loved one died?
□□Yes□□Did this happen within the last 12 months?
□□Yes
□□No
□□No

25.9. Have you ever seen something violent happen to someone (e.g., attacked or beaten) or seen someone killed?

□□Yes□□Did this happen within the last 12 months?
□□Yes
□□No
□□No
25.10. Have you ever had a serious accident?
□□Yes□□Did this happen within the last 12 months?
□□Yes
□□No
□□No
25.11. Have you ever been in combat in a war, lived near a war zone, or been present during a political uprising?
□□Yes□□Did this happen within the last 12 months?
□□Yes
□□No
□□No
25.12. Have you ever experienced a period where you slept in a park or in a temporary residence because you had no money to pay for rent? *(If example needed, abandoned building, the street, a train or bus, in a shelter for homeless people)*
□□Yes□□Did this happen within the last 12 months?
□□Yes
□□No
□□No
25.13. Have you ever been attacked, mugged, robbed, or been the victim of a serious crime?
□□Yes□□Did this happen within the last 12 months?
□□Yes
□□No
□□No
25.14. Has anyone ever injured you with a weapon – gun, knife, stick, etc.?
□□Yes□□Did this happen within the last 12 months?
□□Yes
□□No
□□No
25.15. Has anyone ever hit you, bit you, slapped you, kicked you, or forced you to have sex against your wishes?
□□Yes□□Did this happen within the last 12 months?
□□Yes
□□No
□□No
If under 18 and YES to either 4.8 or 4.9
25.16. Have you discussed it with anybody?
□□Yes
□□No
If NO:
Try to convince to disclose this issue with somebody:
25.17. Is there anybody you could talk to about this?_____
25.18. Would you like me to tell somebody for you?_____
(only if they have children living with them)
The next questions refer to stressful events that might have involved your children
25.19. Has one of you children ever had a serious illness or accident?
□□Yes□□Did this happen within the last 12 months?
□□Yes
□□No
□□No
25.20. Has any of your children have any special needs? *(Medical, mental, or educational)*
□□Yes

□□No

26. PTSD section (PCL-4)

The next few questions are about bad experiences that might have happened to you at any time in your life. When I use the term "bad experience" I mean the things that things that we just talked about *(if needs propting: like seeing bad things in a combat situation, seeing someone killed or seriously injured, a serious car accident, having a loved one die by murder or suicide, or any other experience that either (READ SLOWLY) put-you-or-someone-close-to-you-at-risk-of-serious-harmor-*

death). Show card

26.1. Has anything like this ever happen to you at any time in your life?

□□Yes (If YES, go to qu. 2)

□□No (If NO, skip section)

In relation to that/these horrible experience in the PAST MONTH, have you:

26.2. Had nightmares about it or thought about it when you did not want to?

□□Yes

□□No

26.3. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

□□Yes

□□No

26.4. Been constantly on guard, watchful or easily startled?

□□Yes

□□No

26.5. Felt numb or detached from others, activities, or your surroundings?

□□Yes

□□No

Comment [mv1]: This should be a laminated card, not on the computer

29. Health Problems section

29.1. Do you have any long-standing illness, disability or infirmity? By long-standing I mean anything that has troubled you over a period of time or that is likely to affect you over a period of time?

□□Yes

□□No

(If yes) What is the matter with you? Could you tell me which long standing illnesses you have? CODE ALL THAT APPLIES

29.2. Asthma
29.3. Chronic bronchitis
29.4. Other chest trouble
29.5. Diabetes
29.6. Stomach or other digestive disorder
29.7. Liver trouble
29.8. Rheumatic disorder or arthritis
29.9. Heart trouble
29.10. Cancer. Specify: _____
29.11. Depression or other nervous illness
29.12. High blood pressure
29.13. Stroke
29.14. Migraine
29.15. Epilepsy/fits
29.16. Gynaecological problem: e.g endometriosis/fibrosis
29.17. Other, specify: _____

Appendix 4: Individual characteristics by migrant status

Table 33 Characteristics of migrant women and women born in the UK (including missing values) (n = 959)

Variable	**Non-Migrant (n = 553) n (%)**	**Migrant (n = 391) n (%)**	***Missing migrant status* (n = 15) n (%)**	**Total (n = 959) n (%)**
Socio-demographic characteristics				
Age , years: Mean (SD) Median (25th and 75th percentiles) (Range) *Missing (n=0)*	 40.0 (17.7) 37 (25, 51) (16-89)	 39.5 (14.5) 37 (25, 51) (16-89)	 44.7 (19.0) 40 (28, 63) (21-86)	 39.9 (16.5) 37 (26, 51) (16-89)
Ethnic Category				
White	421 (76.1)	154 (39.4)	12 (80.0)	587 (61.2)
Black Caribbean	44 (8.0)	46 (11.8)	0 (0.0)	90 (9.4)
Black African	29 (5.2)	104 (26.6)	2 (13.3)	135 (14.1)
Asian	13 (2.4)	22 (5.6)	0 (0.0)	35 (3.7)
Other	45 (8.1)	65 (16.6)	1(6.7)	111 (11.6)
Missing	1 (0.2)	0 (0.0)	0 (0.0)	1 (0.1)
Relationship Status				
Single	242 (43.8)	118 (30.2)	4 (26.7)	364 (38.0)
Married/cohabiting	221 (40.0)	191 (48.9)	8 (53.3)	420 (43.8)
Divorced/separated	63 (11.4)	66 (16.9)	2 (13.3)	131 (13.7)
Widowed	27 (4.9)	16 (4.1)	1 (6.7)	44 (4.6)
Number of Children Mean (SD) Median (25th and 75th percentiles) (Range) *Missing (n=0)*	 1.18 (1.43) 1 (0, 2) (0-11)	 1.73 (1.86) 1 (0,3) (0-14)	 2 (1.69) 2 (0,3) (0-5)	 1.42 (1.65) 1 (0,2) (0-14)
Socio-economic status				

Household Weekly Gross Income Category				
£0 - £105	45 (8.1)	41 (10.5)	0 (0.0)	86 (9.0)
£106 - £232	66 (11.9)	64 (16.4)	3 (20.0)	133 (13.9)
£233 - £398	58 (10.5)	65 (16.6)	3 (20.0)	126 (13.1)
£399 - £604	52 (9.4)	46 (11.8)	3 (20.0)	101 (10.5)
£605 or more	250 (45.2)	120 (30.7)	2 (13.3)	372 (38.8)
Missing	82 (14.8)	55 (14.1)	4 (26.7)	141 (14.7)
Employment Status				
In paid employment	311 (56.2)	205 (52.4)	6 (40.0)	522 (54.4)
Unemployed	49 (8.9)	41 (10.5)	2 (13.3)	92 (9.6)
Economically inactive	159 (28.8)	94 (24.0)	6 (40.0)	259 (27.0)
At home looking after children	33 (6.0)	48 (12.3)	0 (0.0)	81 (8.5)
Missing	1 (0.2)	3 (0.8)	1 (6.7)	5 (0.5)
Education level				
No qualification	72 (13.0)	52 (13.3)	5 (33.3)	129 (13.5)
GCSE or equivalent	125 (22.6)	63 (16.1)	2 (13.3)	190 (19.8)
A-level or equivalent	120 (21.7)	116 (29.7)	2 (13.3)	238 (24.8)
Degree level or above	230 (41.6)	153 (39.1)	5 (33.3)	388 (40.5)
Missing	6 (1.1)	7 (1.8)	1 (6.7)	14 (1.5)
Physical health				
Long standing condition (n=936)				
No	323 (58.4)	241 (61.6)	9 (60.0)	573 (59.8)
Yes	227 (41.1)	145 (37.1)	4 (26.7)	376 (39.2)
Missing	3 (0.5)	5 (1.3)	2 (13.3)	10 (1.0)
Social resources				
Social support				
Low support	29 (5.2)	40 (10.2)	4 (26.7)	73 (7.6)

High support	518 (93.7)	344 (88.0)	11 (73.3)	873 (91.0)
Missing	6 (1.1)	7 (1.8)	0 (0.0)	13 (1.4)
Social network size				
Mean (S.E.) [95%CI]	5.1 (1.8)	4.9 (1.9)	4.1 (1.8)	5.0 (1.9)
Median (25th and 75th percentiles)	5 (4, 6.5)	5 (3, 6)	4 (2, 5)	5 (4, 6)
(Range)	(0 – 10)	(0 – 10)	(2 – 7)	(0 – 10)
Missing	1 (0.2)	4 (1.0)	1 (6.7)	6 (0.6)

Table 34 Distribution of childhood stressful life events by migrant status (including missing values) (n = 959)

Variable	**Non-Migrant (n = 553) n (%)**	**Migrant (n = 391) n (%)**	***Missing migrant status* (n = 15) n (%)**	**Total (n=959) n (%)**
Spend time in an institution				
No	527 (95.3)	382 (97.7)	15 (100.0)	924 (96.4)
Yes	26 (4.7)	9 (2.3)	0 (0.0)	35 (3.7)
Taken into Local Authority Care				
No	526 (95.1)	386 (98.7)	15 (100.0)	927 (96.7)
Yes	27 (4.9)	5 (1.3)	0 (0.0)	32 (3.3)
Missing	0 (0.00)	0 (0.00)	0 (0.0)	0 (0.00)
Major accident or illness requiring a week or more in hospital				
No	429 (77.6)	309 (79.0)	11 (73.3)	749 (78.1)
Yes	122 (22.1)	78 (20.0)	4 (26.7)	204 (21.3)
Missing	2 (0.4)	4 (1.0)	0 (0.00)	6 (0.6)
Parental divorce				
No	452 (81.7)	324 (82.9)	13 (86.7)	789 (82.3)
Yes	98 (17.7)	63 (16.1)	2 (13.3)	163 (17.0)
Missing	3 (0.5)	4 (1.0)	0 (0.0)	7 (0.7)
Death of parents				
No	500 (90.4)	340 (87.0)	14 (93.3)	854 (89.1)
Yes	48 (8.7)	46 (11.8)	1 (6.7)	95 (9.9)
Missing	5 (0.9)	5 (1.3)	0 (0.0)	10 (1.0)
Separation from parents				
No	345 (62.4)	242 (61.9)	11 (73.3)	598 (62.4)
Yes	205 (37.1)	144 (36.8)	4 (26.7)	353 (36.8)
Missing	3 (0.5)	5 (1.3)	0 (0.0)	8 (0.8)
Being hit so hard it left bruises or marks				
No	459 (83.0)	298 (76.2)	11 (73.3)	768 (80.1)

Yes	90 (16.3)	89 (22.8)	4 (26.7)	183 (19.1)
Missing	4 (0.7)	4 (1.0)	0 (0.0)	8 (0.8)
Sexual abuse				
No	509 (92.0)	365 (93.4)	14 (93.3)	888 (92.6)
Yes	38 (6.9)	20 (5.1)	1 (6.7)	59 (6.2)
Missing	6 (1.1)	6 (1.5)	0 (0.0)	12 (1.3)

Table 35 Distribution of lifetime stressful life events by migrant status (including missing values) (n = 959)

Variable	Non-Migrant (n = 553) n (%)	Migrant (n = 391) n (%)	*Missing migrant status* (n = 15) n (%)	Total (n=959) n (%)
Living with someone as couple and relationship ended				
No	356 (64.4)	231 (59.1)	6 (40.0)	593 (61.8)
Yes	195 (35.3)	156 (39.9)	9 (60.0)	360 (37.5)
Missing	2 (0.4)	4 (1.0)	0 (0.0)	6 (0.6)
Death of a partner, child, or loved one				
No	259 (46.8)	158 (40.4)	9 (60.0)	426 (44.4)
Yes	292 (52.8)	228 (58.3)	6 (40.0)	526 (54.9)
Missing	2 (0.4)	5 (1.3)	0 (0.0)	7 (0.7)
Witnessing something violent happen to someone				
No	350 (63.3)	253 (64.7)	9 (60.0)	612 (63.8)
Yes	201 (36.4)	133 (34.0)	6 (40.0)	340 (35.5)
Missing	2 (0.4)	5 (1.3)	0 (0.0)	7 (0.7)
Serious Accident				
No	460 (83.2)	305 (78.0)	15 (100.0)	780 (81.3)
Yes	91 (16.5)	82 (21.0)	0 (0.0)	173 (18.0)
Missing	2 (0.4)	4 (1.0)	0 (0.)	6 (0.6)
Being in combat in war, living near a war zone, or being present during a political uprising				
No	500 (90.4)	329 (84.1)	12 (80.0)	841 (87.7)
Yes	51 (9.2)	58 (14.8)	3 (20.0)	112 (11.7)
Missing	2 (0.4)	4 (1.0)	0 (0.0)	6 (0.6)
Experienced period sleeping in a park or temporary residence because money was not available for rent				
No	526 (95.1)	361 (92.3)	14 (93.3)	901 (94.0)

Yes	25 (4.5)	26 (6.7)	1 (6.7)	52 (5.4)
Missing	2 (0.4)	4 (1.0)	0 (0.0)	6 (0.6)
Victim of a serious crime				
No	336 (60.8)	274 (70.1)	9 (60.0)	619 (64.6)
Yes	215 (38.9)	113 (28.9)	6 (40.0)	334 (34.8)
Missing	2 (0.4)	4 (1.0)	0 (0.0)	6 (0.6)
Being injured with a weapon (including a gun, knife, or stick)				
No	513 (92.8)	360 (92.1)	12 (80.0)	885 (92.3)
Yes	38 (6.9)	27 (6.9)	3 (20.0)	68 (7.1)
Missing	2 (0.4)	4 (1.0)	0 (0.0)	6 (0.6)
Being hit, bit, slapped, kicked, or forced to have sex against your wishes				
No	382 (69.1)	298 (76.2)	10 (66.7)	690 (72.0)
Yes	167 (30.2)	88 (22.5)	5 (33.3)	260 (27.1)
Missing	4 (0.7)	5 (1.3)	0 (0.0)	9 (0.9)
A serious accident or illness of child				
No	493 (89.2)	334 (85.4)	10 (66.7)	837 (87.3)
Yes	53 (9.6)	49 (12.5)	4 (26.7)	106 (11.1)
Missing	7 (1.3)	8 (2.1)	1 (6.7)	16 (1.7)
Having a child with special needs (including medical, mental, and/or educational)				
No	511 (92.4)	351 (89.8)	11 (73.3)	873 (91.0)
Yes	35 (6.3)	32 (8.2)	3 (20.0)	70 (7.3)
Missing	7 (1.3)	8 (2.1)	1 (6.7)	16 (1.7)

Table 36 Mental health of migrant women and women born in the UK (including missing values) (n = 959)

Variable	Non-Migrant (n = 553) n (%)	Migrant (n = 391) n (%)	*Missing migrant status* (n = 15) n (%)	Total n (%)
High levels of psychological symptoms[†]				
No	385 (69.6)	278 (71.1)	12 (80.0)	675 (70.4)
Yes	164 (29.7)	111 (28.4)	3 (20.0)	278 (29.0)
Missing	34 (0.7)	2 (0.5)	0 (0.00)	6 (0.63)
CIS-R total score category[††]				
0-11	391 (70.7)	288 (73.7)	12 (80.0)	691 (72.1)
12-17	71 (12.8)	47 (12.0)	3 (20.0)	121 (12.6)
18+	88 (15.9)	56 (14.3)	0 (0.0)	144 (15.0)
Missing	3 (0.5)	0 (0.0)	0 (0.0)	3 (0.3)
Revised Clinical Interview Schedule (CIS-R) primary diagnosis: common mental disorder diagnostic categories[†††]				
No disorder	379 (68.5)	268 (68.5)	11 (73.3)	658 (68.6)
Neurotic, stress-related, and somatoform disorders	88 (15.9)	76 (19.4)	3 (20.0)	167 (17.4)
Depressive disorders	84 (15.2)	47 (12.0)	1 (6.7)	132 (13.8)
Missing	2 (0.4)	0 (0.0)	0 (0.0)	2 (0.2)
Post Traumatic stress disorder (PTSD) screen[††††]				
No	516 (93.3)	357 (91.3)	15 (100.0)	888 (92.6)
Yes	35 (6.3)	28 (7.2)	0 (0.0)	63 (6.6)
Missing	2 (0.4)	6 (1.5)	0 (0.0)	8 (0.8)

[†] This included either meeting the cut off score of 12 in the CIS-R or screening positive on the PTSD screen.

[††]The cut off score defining cases for the CIS-R score is 12, the threshold determined by Lewis et al based on comparisons with the General health Questionnaire and psychiatric interviewers (Lewis et al, 1992).

[†††]This variable was created by amalgamating the 12 primary diagnoses identified from CIS-R scores according to ICD-10 disorders:

- No disorder
- Neurotic, stress-related, and somatoform disorders: non-specified neurotic disorder, generalized anxiety disorder mild, generalized anxiety disorder, obsessive compulsive disorder, mixed anxiety and depressive disorder, specific (isolated) phobia, social phobia, agoraphobia, panic disorder.
- Depressive Disorders: mild depressive episode, moderate depressive episode, severe depressive episode.

†††† This screen identifies a possible case of PTSD if the participant responds positively to three or more items in the screen.

Appendix 5: Distribution of characteristics and exposure to stressful life events by IHDI and GII level

Table 37 Characteristics of migrant women and women born in the UK by IHDI level†

Variable	Born in the UK n=553 (60.57%)	Very Low IHDI level n=103 (11.28%)	Low IHDI level n=75 (8.21%)	Medium IHDI level n=91 (9.97%)	High IHDI level n=91 (9.97%)	*p-value* X^2(df)
	n(%) [95% CI]	n (%) [95% CI]	n (%) [95% CI]	n (%) [95% CI]	n (%) [95% CI]	
Socio-demographic characteristics						
Age , years (n=913)						*0.72*
Mean (S.E.) [95%CI]	44.1 (1.0) [42.2 – 46.0]	42.4 (1.6) [39.3 – 45.6]	43.4 (2.1) [39.1 – 47.6]	44.3 (2.1) [40.1 – 48.5]	41.5 (2.0) [37.6 – 45.4]	
Median (25^{th} and 75^{th} percentiles)	37 (25, 51)	40 (30, 49)	36 (30, 49)	38 (27, 51)	34 (28, 48)	
(Range)	(16 – 84)	(16 – 76)	(19 – 80)	(16 – 89)	(19 – 81)	
Ethnic Category (n=943)						*<0.001****
White	421 (79.3) [75.3 – 82.8]	1 (0.9) [0.1 – 6.4]	18 (23.2) [14.1 – 35.6]	40 (41.0) [30.9 – 52.0]	86 (95.3) [89.2 – 98.1]	$X^2(12)$ = 936.90
Black Caribbean	44 (6.8) [4.9 – 9.6]	1(0.9) [0.1 – 5.8]	3 (5.5) [1.8 – 15.8]	38 (45.5) [34.6 – 56.9]	1 (0.9) [0.1 – 6.3]	
Black African	29 (4.6) [3.1 – 6.9]	93 (89.3) [81.2 – 94.2]	3 (4.4) [1.4 – 13.2]	1 (1.0) [0.1 – 6.6]	0 (0.00)	
Asian and Other	58 (9.2) [6.9 – 12.2]	8 (8.9) [4.4 – 17.0]	51 (67.0) [54.5 – 77.5]	12 (12.5) [7.3 – 20.7]	4 (3.8) [1.4 – 9.7]	
Relationship Status (n=913)						*0.01**
Single	242 (39.3) [35.2 – 43.5]	35 (30.4) [22.0 – 40.2]	15 (17.5) [10.7 – 27.3]	31 (31.2) [22.5 – 41.5]	28 (28.7) [20.2 – 39.1]	$X^2(8)$ = 20.98
Married/cohabiting	221(40.3) [36.2 – 44.6]	45 (42.6) [33.4 – 52.4]	40 (53.3) [41.4 – 64.9]	40 (42.4) [32.6 – 59.9]	49 (53.2) [42.4 – 63.7]	
Divorced/separated/widowed	90 (20.4) [16.9 – 24.5]	23 (27.1) [18.5 – 37.7]	20 (29.2) [19.7 – 40.9]	20 (26.4) [17.6 – 37.5]	14 (18.1) [10.9 – 28.6]	
Number of Children (n=913)						*<0.001****

Mean (S.E.) [95%CI]	1.3 (0.1) [1.2 – 1.5]	2.6 (0.2) [2.2 – 2.9]	1.7 (0.2) [1.3 – 2.1]	2.4 (0.3) [1.8 – 3.0]	1.3 (0.2) [0.9 – 1.7]	
Median (25th and 75th percentiles)	1 (0, 2)	2 (1, 3)	1 (0, 2)	1 (0, 3)	0 (0, 2)	
(Range)	(0-6)	(0 – 6)	(0 – 5)	(0 – 14)	(0 – 10)	
Socio-economic characteristics						
Household Monthly Gross Income Category (n=781)						*<0.001**** $X^2(16) = 56.67$
£0 - £420	45 (10.1) [7.5 – 13.5]	15 (17.8) [10.8 – 27.9]	7 (15.0) [7.2 – 28.7]	8 (11.9) [6.0 – 22.1]	7 (7.1) [3.4 – 14.3]	
£421 - £928	66 (16.5) [13.1 – 20.6]	21 (24.3) [16.4 – 34.6]	13 (21.4) [12.6 – 33.9]	17 (23.4) [14.8 – 35.0]	8 (9.5) [4.7 – 18.2]	
£929 - £1,592	58 (12.5) [9.6 – 16.1]	18 (20.2) [13.0 – 30.0]	12 (22.2) [12.7 – 36.1]	17 (21.8) [13.8 – 32.8]	10 (16.2) [8.9 – 27.5]	
£1,593 - £2,416	52 (10.7) [8.1 – 14.1]	15 (17.8) [10.8 – 27.9]	4 (6.0) [2.2 – 15.1]	16 (19.1) [11.9 – 29.2]	8 (9.2) [4.6 – 17.8]	
£2,417 or more	250 (50.2) [45.4 – 55.1]	17 (19.9) [12.6 – 30.1]	25 (35.4) [24.4 – 48.1]	20 (23.8) [15.0 – 35.5]	52 (58.1) [46.8 – 68.5]	
Employment Status (n=909)						*0.001*** $X^2(12) = 36.24$
In paid employment	311 (53.1) [48.7 – 57.5]	53 (50.6) [40.7 – 60.4]	31 (36.2) [25.9 – 47.8]	49 (51.2) [40.3 – 62.0]	59 (61.6) [50.6 – 71.6]	
Unemployed	49 (8.2) [6.1 – 10.8]	13 (11.47) [6.5 – 19.4]	6 (8.2) [3.7 – 17.5]	6 (5.9) [2.4 – 14.0]	11 (12.7) [7.1 – 21.7]	
Economically inactive	159 (33.5) [29.3 – 38.0]	25 (28.2) [19.8 – 38.4]	21 (35.3) [24.4 – 47.9]	26 (34.3) [24.6 – 45.6]	13 (17.7) [10.4 – 28.5]	
At home looking after children	33 (5.2) [3.7 – 7.2]	11 (9.8) [5.4 – 17.0]	16 (17.7) 10.4 – 28.5]	9 (8.6) [4.5 – 15.9]	8 (8.0) [4.0 – 15.3]	
Education level (n=901)						*<0.001**** $X^2(8) = 52.43$
No qualification	72 (16.8) [13.4 – 20.8]	15 (18.6) [11.4 – 28.8]	6 (10.4) [4.6 – 21.8]	21 (29.7) [20.2 – 41.3]	7 (10.9) [5.2 – 21.3]	
GCSE or A-level or equivalent	245 (42.8) [38.5 – 47.3]	60 (58.5) [48.6 – 67.8]	30 (43.6) [31.9 – 56.0]	46 (48.5) [38.1 – 59.0]	23 (25.2) [16.9 – 35.8]	
Degree level or above	230 (40.4) [36.1 – 44.8]	25 (22.9) [15.9 – 31.9]	37 (46.0) [34.3 – 58.3]	23 (21.8) [14.9 – 30.8]	61 (63.9) [52.7 – 73.7]	
Physical health						

Long standing condition (n=905)						*0.72*
No	323 (54.3) [50.0 – 58.6]	63 (57.8) [47.0 – 67.8]	49 (61.0) [48.3 – 72.3]	54 (55.5) [44.5 – 66.0]	59 (60.7) [49.8 – 70.7]	$X^2(4) = 2.31$
Yes	227 (45.7) [41.5 – 50.0]	38 (42.2) [32.2 – 53.0]	25 (39.0) [27.7 – 51.7]	35 (44.5) [34.0 – 55.5]	32 (39.3) [29.3 – 50.2]	
Social resources						
Social support (N=901)						*0.002***
Low support	29 (6.1) [4.2 – 8.8]	17 (16.1) [10.1 – 24.7]	8 (11.7) [5.9 – 21.9]	9 (11.4) [6.1 – 20.3]	3 (2.9) [0.9 – 8.5]	$X^2(4) = 17.35$
High support	518 (93.9) [91.2 – 95.8]	83 (83.9) [75.3 – 89.9]	66 (88.3) [78.1 – 94.1]	80 (88.6) [79.7 – 93.9]	88 (97.2) [91.5 – 99.1]	
Social network size (n=908)						*0.602*
Mean (S.E.) [95%CI]	5.0 (0.1) [4.9 – 5.2]	5.1 (0.2) [4.6 – 5.5]	4.7 (0.2) [4.3 – 5.2]	4.8 (0.2) [4.4 – 5.2]	5.0 (0.2) [4.6 – 5.3]	
Median (25^{th} and 75^{th} percentiles)	5 (4, 6.5)	5 (3, 7)	5 (4, 6)	5 (3, 6)	5 (4, 6)	
(Range)	(1 – 9)	(2 – 9)	(1 – 9)	(0 – 10)	(2 – 9)	

† Data have been weighted to correct for non-response bias, and for clustering in the household survey. Analysis accounts for the survey design and the weighting. Sample sizes, medians, quartiles, and ranges are unweighted.

* p<.05 ** p<.01 *** p<.001

Table 38 Characteristics of migrant women and women born in the UK by GII level†

Variable	Born in the UK n=553 (63.1%)	Very High GII level n=80 (9.1%)	High GII level n=83 (9.5%)	Medium GII level n=90 (10.3%)	Low GII level n=71 (8.1%)	*p-value* X^2(df)
	n(%) [95% CI]	n (%) [95% CI]	n (%) [95% CI]	n (%) [95% CI]	n (%) [95% CI]	
Age , years (n=877)						*0.83*
Mean (S.E.) [95%CI]	44.1 (1.0) [42.2 – 46.0]	44.9 (2.1) [40.8 – 49.1]	46.4 (2.2) [42.1 – 50.8]	39.5 (1.9) [35.8 – 43.3]	40.9 (2.1) [36.6 – 45.1]	
Median (25^{th} and 75^{th} percentiles)	37 (25, 51)	40 (29.5 – 52.5)	38 (31, 51)	32 (25 – 45)	35 (28, 47)	
(Range)	(16 – 89)	(16 – 80)	(16 – 89)	(17 – 75)	(19 – 81)	
Ethnic Category (n=876)						*<0.001****
White	421 (79.3) [75.3 – 82.8]	2 (3.0) [0.7 – 11.7]	17 (18.4) [10.9 – 29.3]	68 (75.8) [65.5 – 83.7]	64 (90.9) [82.0 – 95.7]	$X^2(12)$ = 508.9
Black Caribbean	44 (6.8) [4.9 – 9.6]	4 (6.2) [2.3 – 15.3]	38 (49.2) [37.4 – 61.1]	1 (1.7) [0.2 – 11.0]	1 (1.2) [0.2 – 8.1]	
Black African	29 (4.6) [3.1 – 6.9]	42 (50.3) [39.2 – 61.5]	2 (2.9) [0.7 – 11.0]	1 (1.0) [0.1 – 6.9]	0	
Asian and Other	58 (9.2) [6.9 – 12.2]	32 (40.5) [30.0 – 51.9]	26 (29.6) [20.2 – 41.1]	20 (21.5) [14.1 – 31.5]	6 (7.9) [3.6 – 16.6]	
Number of Children (n=877)						*<0.001****
Mean (S.E.) [95%CI]	1.3 (0.1) [1.2 – 1.5]	2.4 (0.2) [2.0 – 2.7]	2.5 (0.3) [1.8 – 3.2]	1.2 (0.2) [0.9 – 1.5]	○ (0.2) ○ [0.7 – 1.5]	
Median (25^{th} and 75^{th} percentiles)	1 (0, 2)	2 (1, 3)	1 (1, 3)	1 (0, 2)	0 (0, 2)	
(Range)	(0 – 11)	(0 – 6)	(0 – 14)	(0 – 7)	(0 – 10)	
Household Monthly Gross Income Category (n=753)						*<0.001**** $X^2(16)$ = 57.5
£0 - £420	45 (10.1) [7.5 – 13.5]	11 (19.6) [11.2 – 32.1]	8 (12.2) [6.1 – 23.0]	3 (4.2) [1.3 – 12.4]	9 (13.3) [6.9 – 24.0]	
£421 - £928	66 (16.5) [13.1 – 20.6]	16 (23.3) [14.6 – 34.9]	20 (29.9) [19.7 – 42.5]	10 (14.4) [7.9 – 24.8]	6 (8.3) [3.7 – 17.5]	
£929 - £1,592	58 (12.5) [9.6 – 16.1]	16 (23.5) [14.6 – 35.5]	15 (23.5) [14.6 – 35.5]	18 (25.6) [16.5 – 37.3]	6 (11.7) [5.3 – 23.9]	
£1,593 - £2,416	52 (10.7) [8.1 – 14.1]	8 (13.0) [6.4 – 24.5]	11 (13.0) [6.4 – 24.5]	11 (13.6) [7.5 – 23.3]	6 (8.5) [3.8 – 17.7]	

£2,417 or more	250 (50.2) [45.4 – 55.1]	15 (20.7) [12.6 – 31.9]	17 (20.7) [12.6 – 31.9]	37 (42.3) [31.6 – 53.9]	39 (58.3) [45.7 – 69.8]	
Employment Status (n=874)						*0.003***
In paid employment	311 (53.1) [48.7 – 57.5]	38 (44.4) [34.0 – 55.4]	37 (41.7) [30.7 – 53.6]	51 (53.8) [43.0 – 64.4]	46 (62.0) [49.5 – 73.1]	$X^2(12)$ = 31.1
Unemployed	49 (8.2) [6.1 – 10.8]	11 (12.9) [7.2 – 22.0]	6 (6.5) [2.9 – 14.0]	7 (7.9) [3.5 – 17.0]	8 (11.6) [5.8 – 21.8]	
Economically inactive	159 (33.5) [29.3 – 38.0]	16 (25.5) [16.4 – 37.4]	27 (25.5) [16.4 – 37.4]	21 (27.6) [18.6 – 38.9]	11 (18.4) [10.3 – 30.7]	
At home looking after children	33 (5.2) [3.7 – 7.2]	15 (17.2) [10.5 – 27.0]	11 (11.8) [6.5 – 20.5]	11 (10.7) [6.0 – 18.6]	6 (8.0) [3.6 – 16.9]	
Education level (n=865)						*0.001***
No qualification	72 (16.8) [13.4 – 20.8]	13 (19.1) [11.4 – 30.2]	16 (26.8) [17.1 – 39.4]	11 (15.7) [8.8 – 26.4]	4 (7.5) [2.8 – 19.0]	$X^2(8)$ = 31.1
GCSE or A-level or equivalent	245 (42.8) [38.5 – 47.3]	41 (53.7) [42.4 – 64.6]	40 (46.4) [35.2 – 58.0]	33 (39.0) [29.0 – 50.0]	20 (28.2) [18.5 – 40.6]	
Degree level or above	230 (40.4) [36.1 – 44.8]	24 (27.2) [18.8 – 37.8]	25 (26.8) [17.8 – 38.1]	45 (45.4) [35.2 – 56.0]	46 (64.2) [51.6 – 75.2]	
Long standing condition (n=871)						*0.39*
No	323 (54.3) [50.0 – 586]	44 (50.3) [38.7 – 61.8]	48 (53.6) [41.9 – 65.0]	62 (65.2) [54.2 – 74.7]	42 (53.9) [41.8 – 65.5]	$X^2(4)$ = 4.5
Yes	227 (45.7) [41.5 – 50.0]	35 (49.7) [38.2 – 61.3]	34 (46.4) [35.1 – 58.1]	27 (34.8) [25.3 – 45.8]	29 (46.1) [34.5 – 58.2]	
Relationship Status (n=877)						*<0.001****
Single	242 (39.3) [35.2 – 43.5]	18 (19.5) [12.6 – 28.9]	24 (25.5) [17.7 – 35.2]	25 (25.9) [17.3 – 36.8]	24 (32.4) [22.2 – 44.5]	$X^2(8)$ = 34.4
Married/cohabiting	221 (40.3) [36.2 – 44.6]	42 (50.9) [39.6 – 62.2]	31 (37.7) [27.9 – 48.7]	54 (58.3) [47.2 – 68.6]	36 (51.1) [39.1 – 63.0]	
Divorced/separated/widowed	90 (20.4) [16.9 – 24.5]	20 (29.6) [20.0 – 41.3]	28 (36.8) [26.6 – 48.5]	11 (15.8) [8.9 – 26.4]	11 (16.6) [9.3 – 27.9]	
Social support (N=866)						*0.006***
Low support	29 (6.1) [4.2 – 8.8]	13 (15.3) [8.9 – 25.1]	11 (13.6) [7.8 – 22.7]	3 (4.7) [1.5 – 13.7]	3 (3.7) [1.2 – 11.0]	$X^2(4)$ = 15.2
High support	518 (93.9)	64 (84.7)	71 (86.4)	86 (95.3)	68 (96.3)	

	[91.2 – 95.8]	[75.0 – 91.1]	[77.3 – 92.2]	[86.3 – 98.5]	[89.0 – 98.8]	
Social network size (n=873)						*0.06*
Mean (S.E.) [95%CI]	5.0 (0.08)	4.7 (0.21)	4.7 (0.22)	5.0 (0.20)	4.9 (0.21)	
Median (25^{th} and 75^{th} percentiles)	[4.9 – 5.2]	[4.3 – 5.1]	[4.2 – 5.1]	[4.6 – 5.4]	[4.5 – 5.3]	
(Range)	5 (4, 6.5)	4 (3, 6)	5 (3, 6)	5 (4, 6)	5 (4, 6)	
	(0 – 10)	(1 – 9)	(1 – 10)	(0 – 9)	(2 – 9)	

† Data have been weighted to correct for non-response bias, and for clustering in the household survey. Analysis accounts for the survey design and the weighting. Sample sizes, medians, quartiles, and ranges are unweighted.

* p<.05 ** p<.01 *** p<.001

Table 39 Experiences of stressful life events among migrant women and women born in the UK by IHDI level †

Variable	Born in the UK n (%) [95% CI]	Very low IHDI level n (%) [95% CI]	Low IHDI level n (%) [95% CI]	Medium IHDI level n (%) [95% CI]	High IHDI level n (%) [95% CI]	*p-value* X^2(df)
Childhood Stressful Life Events						
Potentially traumatic childhood stressful life events (n=900)						*0.32* $X^2(4) = 4.78$
Not experienced	355 (64.1) [59.8 – 68.2]	64 (64.6) [54.7 – 73.5]	52 (70.6) [58.7 – 80.2]	51 (56.1) [45.9 – 65.8]	54 (58.3) [47.6 – 68.3]	
Experienced	190 (35.9) [31.9 – 40.2]	36 (35.4) [26.5 – 45.3]	22 (29.4) [19.8 – 41.3]	39 (43.9) [34.2 – 54.1]	37 (41.7) [31.7 – 52.4]	
Other childhood stressful live events (n=904)						*0.01** $X^2(4) = 13.09$
Not experienced	314 (56.9) [52.5 – 61.2]	49 (49.5) [39.2 – 59.9]	43 (57.1) [45.1 – 68.4]	38 (42.4) [32.7 – 52.7]	61 (67.3) [56.8 – 76.4]	
Experienced	234 (43.1) [38.8 – 47.5]	52 (50.5) [40.2 – 60.8]	31 (42.9) [31.6 – 54.9]	52 (57.6) [47.3 – 67.3]	30 (32.7) [23.6 – 43.2]	
Lifetime Stressful Life Events						
Potentially traumatic lifetime stressful life events (n=903)						*0.08* $X^2(4) = 8.92$
Not experienced	164 (28.6) [24.8 – 32.8]	31 (32.0) [23.1 – 42.4]	31 (43.9) [32.4 – 56.0]	25 (27.2) [18.9 – 37.4]	32 (36.5) [27.1 – 47.2]	
Experienced	385 (71.4) [67.2 – 75.2]	69 (68.0) [57.6 – 76.9]	43 (56.2) [44.0 – 67.6]	64 (72.8) [62.6 – 81.1]	59 (63.5) [52.8 – 72.9]	
Other lifetime stressful life events (n=895)						*0.31* $X^2(4) = 4.67$
Not experienced	151 (25.0) [21.6 – 28.8]	22 (20.2) [13.5 – 29.2]	12 (15.2) [8.3 – 26.1]	21 (20.6) [13.7 – 29.9]	24 (26.1) [17.9 – 36.4]	
Experienced	394 (75.0) [71.3 – 78.4]	77 (79.8) [70.8 – 86.5]	59 (84.8) [73.9 – 91.7]	68 (79.4) [70.2 – 86.3]	67 (73.9) [63.6 – 82.1]	

† Data have been weighted to correct for non-response bias, and for clustering in the household survey. Analysis accounts for the survey design and the weighting. Sample sizes, medians, quartiles, and ranges are unweighted.

* p<.05 ** p<.01 *** p<.001

Table 40 Experiences of stressful life events among migrant women and women born in the UK by GII level †

Variable	Born in the UK n (%) [95% CI]	Very high GII level n (%) [95% CI]	High GII level n (%) [95% CI]	Medium GII level n (%) [95% CI]	Low GII level n (%) [95% CI]	*p-value* X^2(df)
Childhood Stressful Life Event						
Potentially traumatic childhood stressful life events (n=864)						*0.48* $X^2(4) = 3.57$
Not experienced	355 (64.1) [59.8 – 68.2]	52 (68.0) [56.6 – 77.6]	47 (56.6) [45.3 – 67.3]	57 (63.2) [52.8 – 72.5]	42 (57.0) [44.9 – 68.3]	
Experienced	190 (35.9) [31.9 – 40.2]	24 (32.0) [22.4 – 43.4]	35 (43.4) [32.7 – 54.7]	33 (36.8) [27.5 – 47.2]	29 (43.0) [31.7 – 55.1]	
Other childhood stressful live events (n=869)						*0.02** $X^2(4) = 12.13$
Not experienced	314 (56.9) [52.5 – 61.2]	39 (49.7) [38.1 – 61.4]	35 (42.50 [32.1 – 53.6]	54 (599) [49.2 – 69.7]	49 (68.2) [56.2 – 78.3]	
Experienced	234 (43.1) [38.8 – 47.5]	39 (50.3) [38.7 – 61.9]	47 (57.5) [46.4 – 67.9]	36 (40.1) [30.3 – 50.8]	22 (31.8) [21.8 – 43.8]	
Lifetime Stressful Life Events						
Potentially traumatic lifetime stressful life events (n=868)						*0.21* $X^2(4) = 6.2$
Not experienced	164 (28.6) [24.8 – 32.8]	29 (39.6) [28.5 – 51.8]	22 (27.4) [18.6 – 38.6]	31 (35.1) [25.5 – 46.0]	26 (36.7) [26.3 – 48.6]	
Experienced	385 (71.4) [67.2 – 75.2]	48 (60.4) [48.2 – 71.5]	59 (72.6) [61.5 – 81.4]	59 (64.9) [54.0 – 74.5]	45 (63.3) [51.5 – 73.7]	
Other lifetime stressful life events (n=861)						*0.09* $X^2(4) = 8.13$
Not experienced	151 (25.0) [21.6 – 28.8]	17 (20.0) [12.5 – 30.4]	11 (12.4) [6.6 – 22.0]	27 (29.0) [20.5 – 39.3]	18 (24.5) [15.8 – 36.0]	
Experienced	394 (75.0) [71.3 – 78.4]	58 (80.1) [69.6 – 87.6]	69 (87.6) [78.0 – 93.4]	63 (71.0) [60.7 – 79.6]	53 (75.5) [64.0 – 84.2]	

† Data have been weighted to correct for non-response bias, and for clustering in the household survey. Analysis accounts for the survey design and the weighting. Sample sizes, medians, quartiles, and ranges are unweighted.

* p<.05 ** p<.01 *** p<.001

Table 41 Distribution of participant characteristics by reason for migration[†]

Variable	Reason for migration			*p-value* X^2(df)
	Family or partner	**A better life**	**Asylum or other political reasons**	
	n (%) [95% CI]	**n(%) [95% CI]**	**n (%) [95% CI]**	
Migration Specific Variables				
Time since arrival in the UK (n=374)				*<0.001***
Mean (S.E.) [95%CI]	22.4 (1.4) [19.6 – 25.1]	13.9 (1.3) [11.4 – 16.4]	17.9 (3.0) [11.7 – 24.2]	
Median (25^{th} and 75^{th} percentiles)	16 (8, 31)	8 (4, 15)	10 (8, 21.5)	
(Range)	(0 – 57)	(0 – 59)	(0 – 50)	
Age at arrival in the UK (n=374)				*0.11*
Mean (S.E.) [95%CI]	23.2 (1.1) [21.1 – 25.2]	25.5 (0.6) [24.3 – 26.6]	22.6 (2.3) [18.0 – 27.3]	
Median (25^{th} and 75^{th} percentiles)	23 (14, 30)	24 (21, 28)	20 (16, 29)	
(Range)	(0 – 70)	(1 – 48)	(2 – 48)	
English as a first language (n=375)				*0.001***
No	90 (53.4) [45.3 – 61.3]	112 (61.1) [53.3 – 68.3]	25 (90.1) [73.1 – 96.8]	$X^2(2) = 13.5$
Yes	77 (46.6) [38.7 – 54.7]	68 (39.0) [31.7 – 46.7]	3 (9.9) [3.2 – 26.9]	
Socio-demographic characteristics				
Age (n=375)				*0.002***
17-29	44 (21.9) [16.2 – 28.9]	57 (28.4) [22.0 – 35.8]	9 (28.7) [15.3 – 47.4]	$X^2(6) = 23.4$
30-39	33 (17.0) [12.2 – 23.2]	67 (33.8) [27.1 – 41.3]	5 (16.7) [7.0 – 34.9]	
40-54	58 (32.3) [25.6 – 39.7]	37 (20.5) [15.1 – 27.1]	11 (37.5) [21.6 – 56.5]	
55+	32 (28.9) [21.6 – 37.4]	19 (17.3) [11.5 – 25.3]	3 (17.1 – 5.8 – 40.8)	
Ethnic Category (n=375)				*<0.001****
White	46 (26.1) [19.7 – 33.6]	98 (53.8) [46.1 – 61.3]	4 (18.5) [7.0 – 40.4]	$X^2(6) = 48.5$
Black Caribbean	32 (21.1) [15.2 – 28.6]	13 (7.8) [4.3 – 13.5]	0	
Black African	52 (29.9) [23.2 – 37.6]	32 (18.5) [13.1 – 25.5]	15 (50.7) [32.4 – 68.8]	
Asian and Other	37 (50.7) [32.4 – 68.8]	37 (19.9) [14.5 – 26.7]	9 (30.9) [16.6 – 50.0]	
Relationship Status (n=375)				*0.21*
Single	42 (22.4) [16.6 – 29.6]	61 (31.8) [25.0 – 39.6]	10 (32.9) [18.2 – 51.9]	$X^2(4) = 6.2$
Married/cohabiting	86 (49.2) [41.3 – 57.0]	84 (46.2) [38.6 – 54.0]	14 (53.2) [34.7 – 70.9]	
Divorced/separated/widowed	39 (28.5) [21.5 – 36.6]	35 (22.0) [16.1 – 29.3]	4 (13.9) [5.3 – 32.0]	
Number of Children (n=375)				*<0.001****

Mean (S.E.) [95%CI] Median (25^{th} and 75^{th} percentiles) (Range)	2.5 (0.2) [2.1 – 2.8] 2 (0, 3) (0 – 14)	1.41 (0.2) [1.1 – 1.7] 1 (0, 2) (0 – 10)	2.1 (0.3) [1.5 – 2.7] 2 (1, 3) (0 – 6)	
Socio-economic status				
Household Monthly Gross Income Category (n=781) £0 - £420 £421 - £928 £929 - £1,592 £1,593 - £2,416 £2,417 or more	 15 (10.9) [6.6 – 17.6] 33 (24.4) [17.6 – 32.9] 32 (24.8) [17.9 – 33.3] 18 (12.8) [8.1 – 19.7] 42 (27.1) [20.2 – 35.3]	 18 (12.7) [7.8 – 20.1] 20 (12.8) [8.3 – 19.2] 25 (16.0) [10.8 – 23.1] 24 (14.6) [9.7 – 21.2] 73 (43.9) [36.1 – 52.1]	 6 (25.3) [11.6 – 46.5] 7 (28.4) [13.8 – 49.4] 6 (28.1) [13.0 – 50.4] 2 (7.1) [1.7 – 25.6] 2 (11.2) [2.8 – 36.0]	*0.006*** $X^2(8) = 23.6$
Employment Status (n=372) In paid employment Unemployed Economically inactive At home looking after children	 80 (44.9) [37.4 – 52.7] 13 (7.2) [4.2 – 12.0] 48 (34.1) [26.9 – 42.0] 26 (13.9) [9.5 – 19.8]	 111 (59.4) [51.3 – 67.0] 17 (9.4) [5.9 – 14.7] 36 (24.1) [17.6 – 32.0] 14 (7.2) [4.3 – 11.8]	 7 (26.0) [12.6 – 46.2] 9 (30.5) [16.3 – 49.7] 6 (25.9) [12.0 – 47.3] 5 (17.6) [7.4 – 36.3]	*<0.001**** $X^2(6) = 27.3$
Education level (n=368) No qualification GCSE or A-level or equivalent Degree level or above	 27 (20.9) [14.7 – 28.7] 84 (51.2) [43.3 – 59.1] 50 (27.9) [21.5 – 35.4]	 16 (11.9) [7.3 – 18.7] 70 (39.3) [32.0 – 47.2] 93 (48.8) [41.0 – 56.6]	 6 (23.0) [10.5 – 43.3] 17 (58.7) [39.4 – 75.7] 5 (18.3) [7.5 – 38.0]	*0.001**** $X^2(4) = 21.1$
Physical health				
Long standing condition (n=370) No Yes	 88 (49.2) [41.4 – 57.0] 78 (50.9) [43.0 – 58.7]	 126 (66.5) [58.6 – 73.7] 50 (33.5) [26.3 – 41.4]	 17 (57.6) [38.4 – 74.8] 11 (42.4) [25.2 – 61.7]	*0.008*** $X^2(2) = 10.6$
Social resources				
Social support (n=369) Low support High support	 15 (8.4) [5.1 – 13.7] 149 (91.6) [86.3 – 94.9]	 14 (8.6) [5.1 – 14.2] 164 (91.4) [85.8 – 94.9]	 6 (22.1) [9.8 – 42.4] 21 (77.9) [57.6 – 90.2]	*0.09* $X^2(2) = 5.3$
Social network size (n=371) Mean (S.E.) [95%CI] Median (25^{th} and 75^{th} percentiles) (Range)	 5.0 (0.2) [4.7 – 5.3] 5 (4, 6) (0 – 10)	 4.9 (0.1) [4.6 – 5.2] 5 (4, 6) (1 – 10)	 3.8 (0.3) [3.2 – 4.4] 4 (3, 5) (0 – 7)	*0.07*

† Data have been weighted to correct for non-response bias, and for clustering in the household survey. Analysis accounts for the survey design and the weighting. Sample sizes, medians, quartiles, and ranges are unweighted.

* p<.05 ** p<.01 *** p<.001

Table 42 Distribution of experiences of stressful life events by reason for migration[†]

Variable	Reason for migration			*p-value* X^2(df)
	Family or partner	A better life	Asylum or other political reasons	
	n (%) [95% CI]	n (%) [95% CI]	n (%) [95% CI]	
Childhood Stressful Life Events				
Potentially traumatic childhood stressful life events (n=369)				*0.55* $X^2(2) = 1.3$
Not experienced	97 (60.2) [52.3 – 67.6]	116 (64.3) [56.8 – 71.8]	19 (70.0) [50.0 – 84.5]	
Experienced	66 (39.8) [32.4 – 47.7]	63 (35.7) [28.8 – 43.2]	8 (30.0) [15.5 – 50.0]	
Other childhood stressful live events (n=370)				*0.04** $X^2(2) = 6.9$
Not experienced	80 (48.9) [41.0 – 56.8]	104 (58.3) [50.5 – 65.7]	20 (73.2) [53.0 – 86.8]	
Experienced	84 (51.1) [43.2 – 59.0]	75 (41.8) [34.4 – 49.5]	7 (26.8) [13.2 – 47.0]	
Lifetime Stressful Life Events				
Potentially traumatic lifetime stressful life events (n=370)				*0.48* $X^2(2) = 1.6$
Not experienced	52 (33.5) [26.3 – 41.5]	61 (34.1) [27.2 – 41.7]	6 (22.0) [9.9 – 42.1]	
Experienced	111 (66.5) [58.5 – 73.7]	118 (65.9) [58.3 – 72.8]	22 (78.0) [57.9 – 90.1]	
Other lifetime stressful life events (n=366)				*0.01** $X^2(2) = 7.9$
Not experienced	28 (15.5) [10.8 – 21.6]	51 (27.6) [21.4 – 34.9]	5 (16.6) [7.0 – 34.7]	
Experienced	134 (84.5) [78.4 – 89.2]	126 (72.4) [65.1 – 78.6]	22 (83.4) [65.3 – 93.0]	

[†] Data have been weighted to correct for non-response bias, and for clustering in the household survey. Analysis accounts for the survey design and the weighting. Sample sizes, medians, quartiles, and ranges are unweighted.

* p<.05 ** p<.01 *** p<.001

Appendix 6: Ethical Approval and ethics application

Research Ethics Office

5.11 Franklin-Wilkins Building
(Waterloo Bridge Wing)
Stamford Street
London SE1 9NH
Tel 020 7848 4077/4070/4020
Email rec@kcl.ac.uk
www.kcl.ac.uk/research/ethics

KING'S College LONDON

Laura Nellums
Institute of Psychiatry
Box PO31
De Crespigny Park
SE5 8AF

07 July 2010

Dear Laura

PNM/09/10-109 The Impact of Migration and Stressful Events on Women's Mental Health and Quality of Life

Thank you for sending in the amendments requested to the above project. I am pleased to inform you that these meet the requirements of the PNM RESC and therefore that full approval is now granted.

Please ensure that you follow all relevant guidance as laid out in the King's College London Guidelines on Good Practice in Academic Research (http://www.kcl.ac.uk/college/policyzone/attachments/good_practice_May_08_FINAL.pdf).

For your information ethical approval is granted until **07 July 2013**. If you need approval beyond this point you will need to apply for an extension to approval at least two weeks prior to this explaining why the extension is needed, (please note however that a full re-application will not be necessary unless the protocol has changed). You should also note that if your approval is for one year, you will not be sent a reminder when it is due to lapse.

If you do not start the project within three months of this letter please contact the Research Ethics Office. Should you need to modify the project or request an extension to approval you will need approval for this and should follow the guidance relating to modifying approved applications: http://www.kcl.ac.uk/research/ethics/applicants/modifications.html

Any unforeseen ethical problems arising during the course of the project should be reported to the approving committee/panel. In the event of an untoward event or an adverse reaction a full report must be made to the Chairman of the approving committee/review panel within one week of the incident.

Please would you also note that we may, for the purposes of audit, contact you from time to time to ascertain the status of your research.

If you have any query about any aspect of this ethical approval, please contact your panel/committee administrator in the first instance (http://www.kcl.ac.uk/research/ethics/contacts.html). We wish you every success with this work.

With best wishes

Yours sincerely

Jim Summers
Senior Research Ethics Officer

c.c. Dr Louise Howard

www.kcl.ac.uk

APPLICATION FOR ETHICAL APPROVAL – HEALTH SCHOOLS

3. RISK CHECKLIST

		Yes	No
A	Does the study involve **participants who are particularly vulnerable** or unable to give informed consent or in a dependent position (e.g. vulnerable children, people with learning difficulties, people with mental health problems, your own students, young offenders, people in care facilities, including prisons)?	☐	☒
B	Will participants be asked to take part in the study without their consent or knowledge at the time or will **deception** of any sort be involved (e.g. covert observation of people in non-public places)?	☐	☒
C	Is there a risk that the highly sensitive nature of the research topic might lead to **disclosures** from the participant concerning their own involvement in illegal activities or other activities that represent a threat to themselves or others (e.g. sexual activity, drug use, or professional misconduct)?	☒	☐
D	Could the study induce **psychological stress or anxiety**, or produce humiliation or cause harm or negative consequences beyond the risks encountered in normal life?	☒	☐
F	Will **financial inducements** (other than expenses) be offered to participants? If so, please state the amount of financial inducement being offered. £10 pounds will be given to participants for their travel expenses and time.	☒	☐

OTHER INFORMATION RELATED TO RISK

		Yes	N/A
	A **human trials questionnaire** is needed and has been submitted	☐	☒

	Will the study place the researcher at any risk greater than that encountered in his/her daily life? (e.g. interviewing alone or in dangerous circumstances, or data collection outside the UK). **Yes** ☒ **No** ☐ **Does the study involve the using a Medical Device outside of the CE mark approved method of use?** (see guidelines) **Yes** ☐ **No** ☒	☒ **Yes,** and I have completed a risk assessment which has been co-signed by the Head of Department/ I have discussed the risks involved with my supervisor or Head of Department and agreed a strategy for minimising these risks. ☐ **No**

Where you have ticked **'Yes' on the risk checklist**, provide details of relevant experience **with reference to those sections**. This **must** include the researcher and/or supervisor as well as other collaborators involved in those sections marked as presenting risk. **(**Do not submit a c.v.)

The researcher has experience in conducting interviews in which sensitive or distressing topics are discussed. The researcher's primary supervisor is a consultant psychiatrist and will be involved in any situations in which the participant becomes distressed to the point of needing additional support or a risk of harm, either to the participant, researcher, or others, is disclosed. Both Supervisors have extensive experience of supervising researchers on projects involving recruitment in the community of women who may be experiencing domestic violence and/or have a history of traumatic events.

14b. If you ticked YES for question 3A on the risk checklist please detail each of the relevant participant groups and indicate how you will deal with issues of competency to consent, perceived pressure to participate or other issues arising from the needs of that particular group. You will also need to attach any correspondence for parents, guardians, carers, key workers etc.

15. PARTICIPANT'S INVOLVEMENT: RISK, REQUIREMENTS AND BENEFITS

15a. State the potential:

- **for adverse effects resulting from study participation.**
- **for participants suffering pain, discomfort, distress, inconvenience or changes to lifestyle.**
- **for sensitive, embarrassing or upsetting topics being discussed/raised.**

Identify the potential for each of above and state how you will minimise risk and deal with any untoward incidents/adverse reactions**.**

Because some of the topics discussed may be sensitive, the interviews may be distressing to the participants. However, the study is not expected to present any risk not present in every day life. A participant may withdraw from the study, have a break, or stop the interview at any point if they feel distressed or do not wish to continue their participation, without having to give any reason. Furthermore, information regarding support services for the participant will be provided if requested or appropriate. If information is disclosed during the interview which indicates a risk to the participant or to others, for example suicidal or violent behaviour, this information will be disclosed to the researcher's supervisors, and a course of action will be identified e.g. contacting their GP. The primary supervisor for the research is a consultant psychiatrist and will be available throughout the course of the research. If during the interview anonymity and confidentiality can no longer be maintained, for example if the interview is interrupted, the participant may choose how to proceed. They may continue the interview if they feel comfortable, take a break, stop the interview, or withdraw from the study entirely.

15b. Please describe any expected benefits to the research participant.

There are no direct benefits to the research participant, though some may find benefit from talking about their experiences. If the participant chooses, she may receive a copy of the final research report.

15f. Is it possible that criminal or other disclosures requiring action (e.g. evidence of professional misconduct) could be made during this study? If yes, detail what procedures will be put in place to deal with these issues. The Information Sheet should make it clear under which circumstances action may be taken by the researcher.

YES ☒ **NO** ☐

The information sheet will describe to the participant that if she discloses any information that reveals a risk to herself or to others that confidentiality may not be maintained. If such information is disclosed, the researcher will disclose the information in question to her supervisors and a course of action will be ascertained. The primary supervisor's position as a consultant psychiatrist ensures all situations will be handled appropriately and the participant's needs will be appropriately addressed.

15g. Under what circumstances might a participant not continue with the study, or the study be terminated in part or as a whole?

If the participant becomes distressed during the interview, she may choose to withdraw from the study, stop the interview, or take a break. Additionally, if she feels at any point that she is uncomfortable with the study or the information she has provided, she may choose to withdraw. If the interview is interrupted at any point and privacy cannot be maintained, or anonymity cannot be guaranteed, or the participant chooses to stop the interview, they may withdraw as well. The interview may also be terminated if the researcher feels she is in an unsafe situation or at risk of harm.

15h. Name the locations or sites where the work will be done.

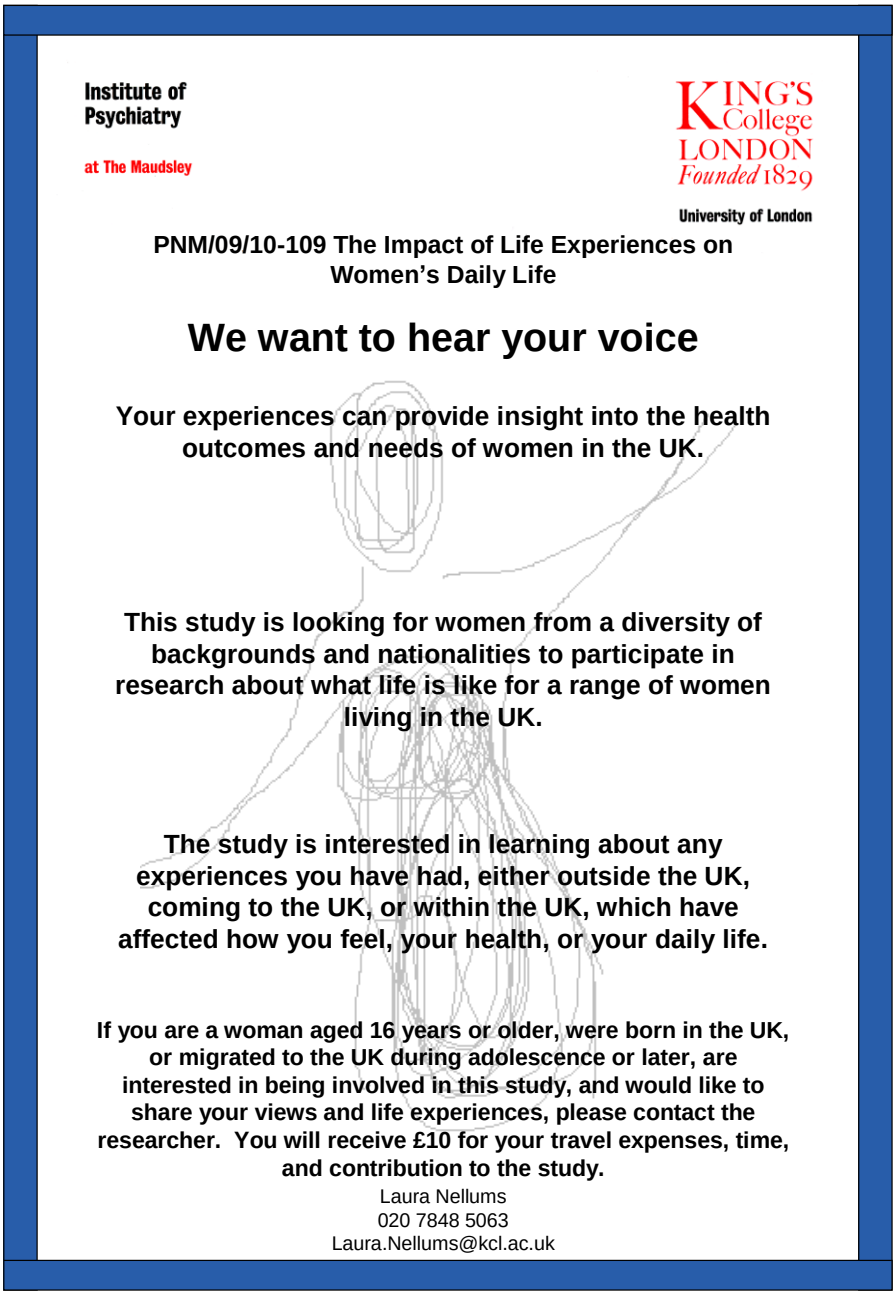
Interviews will be conducted in a location chosen by the participant, or in which the participant feels comfortable. This may include their homes, recruitment sites, or the Weston Education Centre, King's College London. In all cases, the safety of the researcher and the participant will be prioritised. Interviews may be conducted in homes of participants previously interviewed in the SELCoH Study. In these cases, residences will have previously been determined as safe by the SELCoH research team, and interviews will only be conducted during daylight hours. If the area in which the individual resides is deemed potentially risky, an authorised minicab service will be used instead of public transportation. Interviews may be conducted at recruitment sites if relevant organisations or centres can provide private interview settings and anonymity and confidentiality

can be maintained. Interviews conducted at the Weston Education Centre will occur in private settings where anonymity and confidentiality can be guaranteed.

To ensure the researcher's safety during interviews, she will carry a mobile phone at all times. Furthermore, she will inform her supervisors of the location of each interview, the time it is expected to take, and when she starts and ends interviews. If the interview takes longer than expected, she will inform her supervisor, and if the researcher does not make contact within half an hour of the expected time, the supervisor will follow department procedure in determining the most appropriate course of action. If the researcher feels in danger or unsure about her safety, she will withdraw immediately. Furthermore, if a researcher does encounter a difficult situation and can telephone or text, she will contact one of her supervisors or the section secretary, and give a prearranged code word to indicate an emergency situation.

Appendix 7: Recruitment literature, information sheets, and consent forms

7.1 Recruitment poster



7.2 Recruitment letter to gatekeepers/community organisations

PNM/09/10-109 The Impact of Life Experiences on Women's Daily Life

Dear (name of gatekeeper or organisation),

I am currently a PhD student at the Institute of Psychiatry, King's College London. I am pursuing a study entitled 'The Impact of Migration and Stressful Life Events on Women's Mental Health and Quality of Life'.

The qualitative component of my study seeks to investigate what life is like for different women living in the UK through interviews. More specifically, it is interested in the impact of different experiences, including migration and stressful life events, on quality of life, health, and social functioning for women in London. It aims to identify what experiences women in London perceive as significant in affecting their quality of life and health, and how they perceive their ability to function has been impacted. It furthermore hopes to identify how these experiences and the perceived impact of these experiences for first generation immigrant women compare to those for women born in the UK. This data will provide insight into how to address the needs of women in London.

This qualitative study will utilise semi-structured interviews with women aged 16 or older in South East London. It will include women born in the UK and women who migrated to the UK during adolescence or later. I aim to recruit women representing different ages, ethnic backgrounds, nationalities, marital statuses, religions, migrant statuses, and socioeconomic statuses. Non-English speaking women may also be included in this study. I am writing to ask your permission to recruit participants for my study from your location. If you allow me to recruit from your location, I will provide posters advertising the study in addition to information sheets regarding the study that may be distributed to women at your location. These resources will include my contact details so participants may contact me directly if they are interested in participating. I would also hope to visit your site personally to distribute information regarding my study and to identify potential participants.

If you have any questions regarding this study or the use of your site for recruitment, please do not hesitate to contact me. Furthermore, if you are interested in allowing me to use your location to recruit for this study, please contact me at the number or address below. Thank you so much for your time and consideration.

Yours Sincerely,

Laura Nellums

Louise Howard (Supervisor)

7.3 Recruitment letter to participants recruited from community organisations

PNM/09/10-109 The Impact of Life Experiences on Women's Daily Life

Hello,

I am a PhD student at the Institute of Psychiatry, King's College London and would like to invite you to participate in a research project.

This study is interested in speaking with women aged 16 years and older about their daily life. It will include women born in the UK and women who migrated to the UK during adolescence or later. The research consists of an interview in which you and the researcher will have the opportunity to discuss your life experiences, your daily life, how you feel, and your health. The interview will be at a time and place of your choosing, and will take about one hour. You will receive £10 for your travel expenses, time, and contribution to the study.

If you feel you might be interested in participating, please read the information sheet included with this letter, and contact the researcher to schedule an interview. Her contact details, including address, phone number, and e-mail address are written above, and on the information sheet accompanying this letter.

Thank you for your time and consideration. I look forward to hearing from you.

Yours Sincerely,

Laura Nellums

7.4 Information sheet for participants

REC Reference Number: **PNM/09/10-109**

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

PNM/09/10-109 The Impact of Life Experiences on Women's Daily Life

I would like to invite you to participate in this original research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide if you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information.

Aim

This study seeks to investigate how women in the UK perceive their life experiences to have impacted their quality of life, health, and social functioning.

This study is researching what life is like for a range of women living in the UK. I am interested in talking to you about how you feel, your health, and how this affects your daily life and what you are able to do. I am also interested in hearing about any experiences you have had, including experiences outside the UK, coming to the UK, and here in the UK, which you feel are significant or which you believe affect how you feel, your health, or your daily life. There are no direct benefits to you from this study, though you may find benefit from talking about your experiences. However, your participation will provide insight into the health outcomes and needs of women in the UK and thus benefit the wider community.

Involvement

This study is seeking to interview women aged 16 years and older residing in the UK. It will include women born in the UK and women who migrated to the UK during adolescence or later.

If you decide to take part in this study you will be given this information sheet to keep and be asked to sign a consent form. If you consent to participate in this study, you will be invited to be interviewed by the researcher. This interview will take place in a location in which you are comfortable, and can be conducted at Weston Education Centre, King's College London, if that is preferred. The interview will take approximately one hour and can be scheduled for a time convenient for you. It will consist of a semi-structured interview in which you will have the opportunity to discuss your experiences and how you feel your health, your daily life, what you are able to do, and how you feel have been affected.

You will receive £10 for your travel expenses, time, and contribution to the study.

Risks and Benefits

The interview may involve discussion of sensitive topics which may be distressing. You will be able to stop the interview, withdraw from the study, or take a break at any point during the interview. You can also ask the researcher for information on support resources. If during the interview you disclose any information that reveals that you or another individual is at risk of harm or death, this information will be disclosed by the researcher to her supervisors and appropriate action will be taken.

There are no direct benefits to you from this study, though you will be reimbursed for your time and travel costs. Additionally, the information you provide will contribute to an understanding of women's personal experiences, and how their lives have been affected. Ultimately, knowledge gained from this study may allow for the development of more effective interventions focused on the needs of women in the UK. I will write up the results of this study when the project is complete. If you would like, you can receive a copy of the final report of this study or information on any publications from the study.

Anonymity and Confidentiality

This study will comply with the Data Protection Act 1998 and anonymity and confidentiality will be maintained. If you consent to participate, an audio-recording of the interview will be made. The interview will then be typed up and all personal details, like specific names of people and places, will be removed making the transcription anonymous.

After it has been transcribed, the recording will be deleted. Only the researcher who interviews you, her supervisors, and the secretary for the academic section the study is being conducted for will have access to personal information about you, and no other party will have access to information that is identifiable or can be linked back to you. This is to ensure the safety of both you and the researcher. (For non-English speaking participants, in consenting to participate, you consent to the presence of a translator in the interview and thus, the disclosure of personal information to the translator in the interview setting and in transcription of the data.) The written transcript of your interview will be given a unique ID number so it will not be linked to your consent form or personal details.

The primary researcher for this study is: Laura Nellums.

It is up to you to decide whether to take part or not. If you decide to take part you are still free to withdraw at any time and without giving a reason. You may also withdraw your data from the project at any time up until it is published in the final report. If you agree to take part you will be asked whether you are happy to be contacted about participation in future studies. Your participation in this study will not be affected should you choose not to be re-contacted.

Laura Nellums
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London
United Kingdom, SE5 8AF
Laura.Nellums@kcl.ac.uk
020 7848 5063

If you believe this study has harmed you in any way you can contact King's College London using the details below for further advice and information:

Louise Howard (Primary Supervisor)
Institute of Psychiatry
Box P031
De Crespigny Park
London
United Kingdom, SE5 8AF
Louise.Howard@kcl.ac.uk
020 7848 08

7.5 Consent form for participants

CONSENT FORM FOR PARTICIPANTS IN RESEARCH STUDIES

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Study: PNM/09/10-109 The Impact of Life Experiences on Women's Daily Life

King's College Research Ethics Committee Ref: PNM/09/10-109

- Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part.

- If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

- I understand that if I decide at any time during the research that I no longer wish to participate in this project, I can notify the researchers involved and withdraw from it immediately without giving any reason.

- I consent to the processing of my personal information for the purposes explained to me. I understand that such information will be handled in accordance with the terms of the Data Protection Act 1998.

Participant's Statement:

I _____

agree that the research project named above has been explained to me to my satisfaction and I agree to take part in the study. I have read both the notes written above and the Information Sheet about the project, and understand what the research study involves.

Signed Date

Consent to be re-contacted:

As part of this research, the researcher may be interested in re-contacting you to gain feedback from you in the analysis stage.

I agree to be contacted in future by the researcher who may like to invite me to participate at a later stage in the research. I understand by agreeing to this, all I am doing is allowing the researcher to re-contact me. Upon being re-contacted, I am under no obligation to agree to further participation. If I agree to further participation in future after being re-contacted, I would receive more information before being asked to sign a consent form, and in all cases would be free to withdraw my consent at any time.

Signed Date

Contact Details: _____

7.6 Confidentiality agreement for translation or transcription

PNM/09/10-109 The Impact of Migration and Stressful Events on Women's Mental Health and Quality of Life

CONFIDENTIALITY AGREEMENT

This document is a legally binding agreement is made on…….... 2010 by and between **King's College London** of Strand, London WC2R 2LS, (referred to the 'College' in this Agreement), and ……..of …….. (referred to as 'I' or 'me'' in this Agreement).

I am providing translation and transcribing services to the College in:
(i) face-to-face interviews, and (ii) with regard to documents and recordings, and the College therefore wishes to disclose to me in confidence copies of material to translate or involve me in situations in which I will be involved in a translating and/or transcribing role in confidence (the 'Purpose').

I will be supplied with material, some of which is sensitive, proprietary or confidential, in printed, electronic and audio media, and will also be involved in live interviews by College researchers in the course of which I will be exposed to similar information in written and/or oral form, all of which constitutes Confidential Information.

'Confidential Information' refers to information, data and/or ideas disclosed to me during the study, including names, addresses, contact information, personal information, and any other information held about individuals, disclosed to me in face to face interviews, or in any other way throughout the course of my involvement with the study.

- I agree to observe **complete confidentiality** towards any Confidential Information that is disclosed to me in whatever form during my employment with this study.
- I confirm that I will not discuss or disclose any information regarding study participants with anyone other than researchers involved in this study.
- I agree not to make use of any of the confidential information, either directly or indirectly, except solely for the Purpose.

I will not do any of the following without explicit permission from the primary researcher or her supervisors:

- I will not store or transfer personal data, send personal information by email or text message, remove personal information from the College's premises at the Institute of Psychiatry, access study databases remotely, or disclose passwords/codes/pins.
- I will not attempt to access or investigate information that I am not authorised to.

- I agree not to copy, modify, or create other works based on any part of the Confidential Information.

- I will ensure that all information is stored securely and is not accessible to external parties. Any confidential information that is not to be stored will be destroyed in an appropriate and secure manner.

The obligations of confidentiality are binding on me from the date of signature of this agreement and shall apply to all Confidential Information disclosed to me unless and until a particular item of Confidential Information lawfully enters the public domain; any Confidential Information that does not enter the public domain lawfully shall remain confidential under the by the obligations in this agreement.

I understand that I have a legal duty to ensure the lawful processing, confidentiality and security of personal information under the Data Protection Act 1998. I understand that any breach of confidentiality of personal information is an offence in law.

Signed for and on behalf of
King's College London

Signed by ……

.....

.....

Date.....

Date.....

Appendix 8: Topic guide

PNM/09/10-109 The Impact of Life Experiences on Women's Daily Life
Laura Nellums
Section for Women's Health
Health Service and Population Research Department
Institute of Psychiatry, King's College London
Funded by NIHR BRC PhD studentship Stakeholder Participation theme / ORS Award / King's International Graduate Scholarship

Topic Guide:

Semi-structured interview regarding women's experiences of migration, stressful life events, and mental health and well-being

Describe the study to the participant verbally and verify that the participant understands the study and agrees to participate, including being recorded. Additionally, ask participant if she would like to have an advocate present in the interview.

Thank you for agreeing to take part in my study and to talk to me about your experiences. I'll describe what I am studying and what I am interested in talking with you about today, and then answer any questions you may have before we begin.

Purpose:

This study is part of my research into what life is like for different women living in the UK. I am interested in hearing about any experiences you have had, including experiences outside the UK, coming to the UK, and here in the UK, which you feel are significant or which you believe affect how you feel, your health, and your daily life. I am interested in what is significant to you, and there are no right or wrong answers or thoughts.

Confidentiality:

I want to emphasise that your participation in this study and everything you and I discuss during this interview will be confidential and kept anonymous. I will tape record the interview and then will type it up later. When I do this, I will take out all personal details as I type the transcript.

If you wish to stop the interview or take a break at any point, please feel free to do so. Also, if for any reason you wish to withdraw from the study you may do so at any time.

Before we begin, do you have any questions you would like to ask me?

Opening

I'd like to start by hearing a little bit about your life.

Can you tell me when and where you were born?

Did you grow up there?
What was that like?
…

Migration (if relevant)

Can you tell me about your home country?
Where are you from?
What was life like?

How did you feel in your home country?
What was that like for you?
(Tell me more)

Can you tell me about the experience of leaving your home country?
When did you leave?
What was happening around the time you left?
Why did you leave?
Who did you leave behind?
What did you leave behind?

Can you tell me about how you were feeling when you were leaving your home country?
What were your thoughts or feelings about immigrating?
What was that like for you?
(Tell me more)

Can you tell me about your journey leaving your home country and eventually arriving here?
When did you come to the UK?
Tell me about your reasons for coming to the UK ultimately?
Where else did you go?
Who did you share that journey with?
Were there any significant events?

Can you tell me about how you felt during your journey?
How did you feel during this period of transition?
The people you travelled with?
Yourself?
Your goals and expectations?
The future?
Feelings about significant events?

What was that like for you?

(Tell me more)

Can you tell me about your experiences arriving here?

What was it like?
Significant events or memories that stand out
How did you feel?

Can you tell me about some of the challenges you have faced or still face having come from your home country to the UK?

What has been difficult?
How has that made you feel?

Daily Life

…Tell me about your life leading up to now.

Can you tell me about your daily life now? Can you describe what do you do on a daily basis?

Routines (including work etc)
What do you enjoy doing?
What is difficult? What is stressful?
Who do you interact with regularly? (Partner, children, friends, groups etc)

Can you tell me about any significant changes in your daily life? In the past year? In the past five years? Since you have been here?

What you do?
Where you live?
Your routines?
When were these changes?
Where were you when things changed?

Can you tell me about your goals?

Have your goals or hopes changed?

Well-being, and changes in well-being/functioning/quality of life

Can you tell me about how you currently feel?

Are there any ways in which you feel different from what is normal for you or 'out of tune' with how you normally feel?

(Have there been times when you felt different that what is normal for you or 'out of tune' with how you normally feel?)
How would you describe this? (What is that like for you?)
(Tell me more)

Can you tell me about how feeling different impacts or impacted on your daily life?

What you are able to do?
Relationships?
Social activities?

When did how you feel change? What was happening around the time you started feeling this way?

Can you tell me about what you think has made you feel different or caused you to feel this way?

Why did how you feel start changing when it did?

Experiences linked to changes in well-being

Can you tell me about any aspects of your life in your home country, experiences, or events there which you feel impact on how you feel now?

Have there been significant aspects of leaving your home country and your journey here or experiences or events during this time which you feel impact on how you feel now?

Can you tell me about if experiencing the transitions of migration at a similar time to when you experienced the events you have told me about impacted on you or how you feel compared to if you had experienced these things separately or on their own?

Have there been significant aspects of being here or experiences or events which impact on how you feel now?

How do these experiences or events make you feel?

In what ways do you feel like these experiences change the way you feel or what you are able to do?
What is that like for you?

Can you tell me about how think your experiences or how you feel compares to the experiences of other people or how they feel?

Stressful Life Events

If you don't mind, I'd like to ask you about more specific types of events you may have experienced.

Remember, this conversation will be kept completely confidential.

Can you talk to me about anything that has happened to you that has felt hurtful or abusive?

I'd like to ask you specifically about violence against women, or gender violence. It is very common and is experienced by 1 in 4 women at some point in their lives. This violence can include physically, sexually, psychologically, financially or emotionally hurtful or abusive acts, threats of these acts, coercion, or other limitations of your freedoms.

Can you tell me about anything you feel might be similar to this that has happened to you?

Can you tell me about what happened and how it made you feel?

Some people feel that experiences like a serious accident or illness, financial strain, changes in or the loss of relationships, physical assault, witnessing violence, or the death of a loved one impact on how they feel.

Can you tell me about anything like this you have experienced? How has/have these experiences affected how you feel, what you are able to do, or your daily life?

Resilience and Coping

Can you tell me about how you cope with any of the experiences or events you have told me about?

Are there things you do in your daily life to help with these experiences or events?

Can you tell me about any events or experiences that have made you feel better?

Can you tell me about how you cope with any of the changes in how you feel or changes in your daily life affected by how you feel?

Can you tell me about the resources you have or have had that helped you during difficult experiences or helped you feel better?

People, personal items, services, activities…?
Here in the UK?
During migration?
In your home country?

Can you tell about other things you worry about?

Can you tell me about these things?
How do these worries affect you or your daily life?

Is there anything else you would like to discuss or share? Can you think of anything relevant to these themes we haven't had the opportunity to talk about or which I might now have known to ask?

Additionally:
How are you doing? How has this interview made you feel?

If you would like to talk more about your experiences or would like support for these experiences or how you feel now, I have some resources for you.

Closing note:

Thank you for your time and for contributing to this study. Thank you so much for sharing your thoughts and details about your own life and experiences. Many of these things are difficult to think about, and it is brave of you to share them. I enjoyed this opportunity to speak with you about them and am grateful you shared your thoughts and experiences with me. Your experiences provide valuable insight into women's lives and needs here in the UK.